FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

February 1, 2016

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

Dear Sir or Madam,

Families USA is a non-profit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all. We appreciate the opportunity to comment on CMS-10440- Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and Children's Health Insurance Program Agencies. This letter recommends several improvements to the collection of information through the electronic and paper applications for the federally-facilitated marketplace. Many of our recommendations are based on feedback from our Enrollment Assister Network, which is comprised of nearly 6,000 assisters from across the country. The changes we recommend will serve to improve the application and enrollment process and will have significant impacts on the both the completion and results of Marketplace applications.

We appreciate your consideration of our recommendations on this proposed collection of information. Please contact Elizabeth Hagan at ehagan@familiesusa.org or Kara Nester at knester@familiesusa.org with any questions.

Sincerely,

Elizabeth Hagan
Senior Policy Analyst

Kara Nester
Policy Analyst

FamiliesUSA.org
1201 New York Avenue, NW, Suite 1100
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

General Comments on the Paper and Online Applications

Families USA appreciates the significant amount of improvements made to the application over the past three years. We appreciate the opportunity to recommend additional improvement and the willingness to hear our feedback. We encourage the continued use of consumer testing and stakeholder input to make the application easy to navigate and consumer-centric.

Regardless of how a consumer applies for coverage, the process should be as simple and streamlined as possible in order to minimize the burden on applicants. This includes presenting the fewest number of screens possible and avoiding duplicating questions. In addition, the application questions should be written at a reading level that is appropriate for the majority of Americans. Finally, we encourage the Centers for Medicare and Medicaid Services (CMS) to work towards offering paper and online applications in a wide array of languages.

Because the vast majority of consumers enroll in coverage through the online platform, the focus of our comments is on the online application rather than the paper application. To the extent possible, we recommend that our comments on the online application extend to the paper application as well.

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

Marketplace account

ID Proofing

While we understand the necessity for protecting individuals' identities, the current identity proofing process has been problematic for many applicants. The current process has led to many individuals facing significant barriers to successful and timely enrollment.

Currently, the ID proofing process relies on credit histories alone, which poses significant problems for many uninsured individuals, including individuals who have limited credit histories, immigrants, and those who are victims of identity theft. Families USA recommends expanding the data sources used in the identity proofing process so that more individuals applying will be able to complete the ID proofing process in order to complete enrollment. For example, the marketplace can use information from state programs to aid in the ID proofing process.

We also recommend that some applicants be able to continue with the application process and submit an application before the full ID proofing process is complete. This will allow the applicant to move forward with the application process and have their identify checked after the application is submitted This will ensure that the identity proofing process does not bar or highly burden consumers who might have remote identity proofing barriers. Allowing this to occur is especially important for individuals who are receiving in-person assistance, given that they have

allotted time out of their schedule to receive help. The identity proofing process should not bar consumers and assisters from accessing the rest of the application. This change will allow for consumers with ID proofing challenges to not have to drastically adjust their schedules, apply without in-person assistance that they desire, or forgo applying altogether.

Create an account

We recommend that the option to apply over the phone be visible at this stage/screen in the application process. This is especially important for consumers without email accounts since they may run into barriers at this stage in the online application, given the need to have an email address to apply online.

We recommend that the security questions asked when creating an account be expanded upon and consumer-tested. Many of the security questions currently available are not culturally appropriate and do not resonate with applicants, making the questions difficult to answer. We strongly urge CMS to create questions that are more appropriate for the diverse population applying for coverage.

Account settings

We recommend that text be its own separate selection from email notifications. Currently, the application presents two selections to receive notifications: email or standard mail. Text is only presented as an option after an applicant selects to receive email notifications. Keeping text and email selections separate is important because consumers may have cellular network service and not regular internet access. For this reason, we should treat these as separate.

Report a life change

Families USA recommends that the life changes presented to applicants in this section align more closely with qualifying life events that allow individuals to enroll through special enrollment periods (SEPs). This change will make consumers aware of the availability of SEPs by providing them with information about the situations that warrant reporting a change.

Report a move to a new state:
We recommend making this section more comprehensive so consumers are aware that they should report most permanent moves, rather than only reporting moves to another state. This is important because even changes in a region can affect the service area of a plan. A consumer might need to switch plans if their current health plan does not have in-network providers in their new region. In addition, any move is important to report because of a change in address. The Marketplace address records should reflect current addresses so that information can be communicated to the consumer in a timely manner.

Report a change in my household's income, size, or other information:
We recommend listing all circumstances that would warrant a report in circumstances to the Marketplace, such as a change in family size due to the birth of a child. This will assist in

educating consumers about the Marketplace and what life changes can affect their health coverage or the cost of health coverage.

Get Started

Contact preferences

We recommend changes to the question about an applicants' preferred written language. The answer to this question affects the language used in the eligibility determination notice. This can be a straightforward concept for many applicants completing the application on their own. However, when applicants are working with assisters, this question can pose problems, particularly when an English-speaking assister is working with a consumer who prefers notices in Spanish. We recommend that applicants who indicate a language preference other than English be given the option to receive two notices; one for themselves in their preferred language and one for their assister.

Further, we recommend that the application asks about language preference for all applicants on the application, not just the applicant filing out the application. This will ensure that all applicants are able to understand details of their coverage.

Help applying for coverage

We recommend that the optional questions asking about enrollment assistance under this section be required. It should be made clear that the question is marked "optional" because not all applicants use an assister to help with the application; it should not indicate that this is an optional question for assisters to fill out. The data that is collected here will help inform assister programs and produce national data on how assisters are helping with enrollment.

Help paying for coverage

We recommend adding more context to the question asking whether someone wants to find out if they can get help paying for health coverage. We recommend adding more language to indicate who will be eligible, such as, "you may qualify for financial assistance if you earn up to $xx/year." Providing context will give individuals a point of reference when answering the question.

Tell us about each person

[FNLNS]'s information

We recommend the consumer-tested two part question regarding the sex and gender identity of the individual applying for coverage. For some consumers, sexual identity may not be as clear cut as checking one box or another. Others might fear discrimination from health care providers when checking one box vs. another. We have heard from several enrollment assisters that some applicants have difficulty answering this question given that an individual's sex at birth may vary from their gender identity. We recommend presenting a two-part gender identity question that

asks current gender identity along with the sex listed on original birth certificate. This presentation will gather information in a way that is more inclusive of the LGBTQ community. Gathering this data will also help understand and address disparities affecting the transgender population. Finally, the two-part question will reduce the number of identity verification failures due to a gender mismatch because transgender applications will no longer have to choose to misrepresent themselves or risk failing identity verification and having their application delayed.

We recommend adding a consumer-tested question about sexual orientation as an optional question with the current questions about race and ethnicity. This data should be optional but should be gathered to ensure that all individuals have the same access to coverage.

We are pleased to see the additional question prompting applicants to fill in the SSN section if left blank. This helps explain to consumers what the information is used for and reduces the number of inconsistencies that consumers face.

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.

The issue is that 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 they use to prove their immigration status and those numbers are used to run 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 then 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 Affordable Care Act. 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.

We also recommend adding additional information about immigration documents and entering in information contained on immigration documents. For example, applicants waiting on new documentation in the mail should have a way to enter in some information in the interim. There are several situations where individuals have eligible immigration status but do not have documents in hand, such as when documentation has expired but the individual's status has not and new documentation is pending. We recommend providing additional guidance on what information can be provided and a space for attestation when status is pending or in the mail.

Family & household

We applaud CMS for the additional text in the application to explain why filing taxes is important for individuals receiving premium tax credits. We recommend adding subsequent text that tells consumers below the tax filing threshold that they need to file taxes as well.

We recommend adding a question eliciting whether an individual is filing as head of household if they indicate that they are filing separately from their spouse. Currently, applicants have to rely on a workaround if they file as head of household, but most applicants not working with savvy assisters have no way to know the workaround. Further, applicants are currently given no explanation of what the implications are for filing as head of household. Adding this question will capture individuals with this filing status who are eligible for premium tax credits (PTCs) now but unaware of their eligibility because they indicate on their application that they are married filing separately. We also recommend additional screening questions for those who meet the exceptions for married filing separately, such as spousal abandonment and domestic violence.

Language Access

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

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

application counselors, brokers and others who will be assisting limited English proficient (LEP) individuals.

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

More about this household

We believe the current questions on disability and whether the applicant requires assistance with activities of daily living (ADLs) will not identify whether an applicant may be eligible for Medicaid on a basis other than MAGI or medically frail. Since the benchmark benefits available to newly eligible adults will likely be less robust than those in traditional Medicaid, is it important that applicants have a full opportunity to determine eligibility for the health insurance program that best suits their needs. Furthermore, research has consistently shown that asking people if they have a disability does not accurately identify people with disabilities. As such, we think it is best to ask a broadly inclusive question first, and allow trained state employees to make a later determination on whether someone does or does not have a disability for the purpose of state benefits.

Thus we suggest that the application should focus on functional limitations rather than asking an individual to indicate that they have a "disability." People will often resist the label of "disability," but recognize that they have reduced functional capacity. For example, someone who is aging may readily acknowledge that they are having trouble hearing or seeing, but will not check that they "have a disability." People may also be fearful that answering yes to the question will have a negative consequence such as higher prices or being turned down for the insurance.

Therefore, we recommend that the application include the six questions used by the American Community Survey and several other federal surveys asking about functional limitations to help identify persons with disabilities. The questions should be accompanied by an explanation informing applicants that they may be entitled to a greater array of benefits if found eligible for traditional Medicaid. These additional questions may also help distinguish medically frail individuals who are also exempt from benchmark coverage.

Income

We recommend additional guidance in the income section of the application to ensure that consumers are including the proper income amounts and understand when to exclude specific sources of income. For example, language should be added to make it clear that a tax dependent's income only needs to be reported when the dependent is required to file taxes. This should be accompanied with the tax filing threshold so applicants are better able to answer the

question. Even a small amount of income being reported in error can have significant implications on someone's eligibility for premium tax credits and cost-sharing reductions.

We also recommend that individuals are more easily able to report income that they receive for only a portion of the year. When applicants report how much they make hourly, weekly, monthly, etc., they should be able to modify how long they receive this income, with the default being the full year. This will allow individuals with short-term or seasonal jobs to better estimate income in the application.

APTC Program Questions

Special Enrollment Periods

Special enrollment periods (SEPs) are an important tool for consumers to maintain continuity of coverage and ensure coverage when changes in circumstance occur. While approximately one million consumers used special enrollment periods between February 23, 2015 and June 30, 2015, many additional consumers continue to be eligible for SEPs through the Marketplace that have not enrolled. Providing additional guidance in the application, as well as marketing the availability of special enrollment periods, will aid in informing additional consumers of opportunities to enroll in coverage outside of open enrollment periods. We recommend adding additional questions within the special enrollment period screening section of the application to assist consumers in identifying and enrolling through special enrollment periods. This measure will give consumers a clearer idea of which life circumstances enable them to enroll though SEPs so eligible consumers are able to successfully enroll

We recognize that insurers have raised concerns about SEP usage by enrollees. While there has been an absence of data that special enrollment periods are being used inappropriately, additional guidance and questions for consumers will help clarify which special enrollment periods are appropriate to ensure that SEPs are being used correctly. Families USA believes that this is a good method for filtering consumers and correctly identifying those who are eligible for special enrollment periods without placing an undue burden on applicants. We strongly encourage CMS to avoid placing additional requirements, such as verification or documentation, on the consumers when applying for an SEP. Additional requirements will most likely discourage consumers from applying and decrease the number of consumers who complete the entire process. Below are several examples of questions that can be asked of consumers and additional information provided through the application:

Loss of minimal essential coverage:
Families USA recommends adding further screening questions and help text for this SEP. Applicants have had confusion understanding this SEP and when it should be used. We recommend adding help text to the original question asking about the loss of health coverage to clarify what conditions do not qualify for a loss of health coverage SEP. For example, "loss" does not include voluntary termination of coverage or termination by the insurer due to nonpayment of premiums. In addition, we recommend adding additional screening questions to determine what situation best classifies the recent loss of health coverage, such as loss of employer coverage, expiration of COBRA, loss of Medicaid or CHIP, etc. This will

be useful in consumers' understanding of SEPs, as well as gathering information for additional outreach and enrollment opportunities.

Recent move:

We are pleased that the SEP offered for those who move will be available prospectively beginning in 2017, as this will enable greater continuity of coverage. We recommend a few changes to accompany that new policy. Specifically, we recommend adding a space on the application to explain a recent move that does not meet the screening question of a move to a new zip code. This will capture consumers who might move within the same zip code but still qualify for a SEP due to change in their service area. We also recommend that guidance be added to help consumers that are in the process of transitioning to new addresses but do not yet have a permanent residence. For example, many individuals may relocate to a temporary address within the same service area prior to obtaining a permanent address. An individual in transition, but without a permanent address, is still eligible given their intention to relocate. This should be made clear and information should be provided about which address to use during the application. This will capture situations such as when a new resident moves to an area while waiting for an apartment, are in the process of buying a home, etc. A large move often happens over a period of time and not all at once, and this should be considered when executing the move SEP.

Further, we recommend additional language be added to the application that indicates what an applicant should do if they intend to move out of state. For example, if an applicant is moving from a SBM to an FFM, it should be made clear that the applicant should enroll in coverage through the place they ultimately intend to reside.

Release from incarceration:
We recommend modifying the questions for release from incarceration to align closer with policy and practice. This includes modification to reflect that an individual can apply for coverage prior to release. Also, there should be considerations to reflect that an incarcerated individual may have a temporary address prior to a permanent address, which is frequently the case for those who are recently released from incarceration. Finally, there should be further guidance in the questions as to what qualifies as "incarcerated."

We recommend additional questions to the SEP portion of the application to reflect the full set of conditions that grant an individual with SEP eligibility. This includes moving out of the Medicaid coverage gap and exceptional circumstances. We have heard from assisters that many of these SEPs currently granted by the call center are provided to consumers inconsistently. Including a comprehensive list of SEPs on the application will inform consumers, make applying for coverage through these SEPs easier, and make the application more consistent. Applicants should not be faced with a burdensome application process when they are eligible for SEPs.

Review and sign

Eligibility results:

We applaud CMS for the recent improvements made to the eligibility results of the application. We have heard from several assisters that the red text for pending eligibility results is a great improvement that has been very helpful for both assisters and the consumers they serve. We recommend making additional improvements to the eligibility results to improve consumer understanding of their eligibility and next steps that need to be taken to remain eligible. Families USA also recommends reformatting the presentation of eligibility results to make it easier to read and understand. While progress has been made in this area, we recommend creating clearer indication of the level of financial assistance available for consumers.

This includes adding in information that is used to determine eligibility within the displayed eligibility results. This change will help consumers understand the calculation of the results and whether the results were correctly determined. This will also go a long way in spotting errors when filling out the application and can aid in follow-up.

Thank you for this opportunity to offer recommendations to Marketplace application, which will further streamline the enrollment process. Please direct any questions about these comments to Elizabeth Hagan at Ehagan@familiesusa.org or Kara Nester at KNester@familiesusa.org.