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

RE: 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

Dear Sir or Madam:

Thank you for the opportunity to comment on the applications to support eligibility determinations for enrollment through health insurance marketplaces and for Medicaid and the Children's Health Insurance Program. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Our comments begin on the following page. If you have any questions or need any further information, please contact Mara Youdelman, Managing Attorney of NHeLP's DC Office (youdelman@healthlaw.org; (202) 289-7661).

Sincerely,

Elizabeth G. Taylor,
Executive Director

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Attachment A: 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

A. Create an Account
B. Transition to a Full Account

We continue to have concerns that many individuals have difficulty setting up a "full" account given their lack of credit history and thus inability to answer the security questions. This includes in particular, young adults and immigrants who have yet to establish credit history. We encourage HHS to examine methods of more expeditiously allowing these individuals to create full accounts without having to contact Experian before going back to the marketplace to send in documents for identity verification. We support the comments of the Center on Budget and Policy Priorities regarding their recommendations for improvements to the identity proofing process.

Further, we recommend that HHS allow minors to apply without an adult. Some minors may be emancipated and thus are lawfully recognized as independent of their parents. These individuals should not have to apply through another adult. Further, homeless youth should be able to apply independently and not have to utilize a surrogate on their application. Finally, some minors may need health coverage for services that their parents/guardians would not necessarily approve of and that should not be a bar to applying for coverage if the individual is otherwise eligible.

We also recommend that HHS allow consumers to select a username and not default to the consumer's email as the username. Some consumers only set up email accounts to get access to an eligibility notice and may not have access to that email during future open enrollment periods. Expecting a consumer to remember the email account they may have initially applied with can create a barrier to reenrollment. Instead, consumers need to be able to select a username and password, and to be able to reset those identifiers without needing access to the original or subsequent email account. Instead, as with many other websites, consumers should be able to select reminder questions, get text messages (rather than emails) with links to reset a username and/or password, and have other abilities to reset these identifiers if the consumer no longer has access to a prior email account.

We support the comments of the Center on Budget and Policy Priorities regarding needed changes to the remote identity proofing (RIDP) process.

C. Account Settings

We have heard from a number of consumers who initially indicated a preference for email communications that when they have attempted to switch to mail communications (often due to the lack of regular use of email or because an email address is no longer valid), that the system does not recognize the new preference. We thus recommend both 1. test the technology to ensure a switch in a communication preference is effectuated; and 2. during initial enrollment and every reenrollment, have the consumer affirmatively confirm his communication preference.

D. Report a Life Change

Since an SEP (Special Enrollment Period) is available to any consumer who moves to an area with new or different qualified health plans, we believe the question listed here -- You moved to a new state -- is too limiting and may mislead consumers who are eligible for the permanent move SEP from accessing it. We recommend changing the language to -- "You moved to a new state or a new area of your state that offers different qualified health plans." Further, under 1.a., the language should be modified to have a consumer check a box whether she is moving states (in which case the current language applies) or moving to a different area of her state in which case she should be evaluated for SEP eligibility.

Further, we are concerned that some pregnant women are involuntarily shifted from their marketplace coverage when reporting their pregnancies as a life event. The U.S. Department of the Treasury (Treasury) and Internal Revenue Service (IRS) have issued guidance stating that women who become pregnant while enrolled in a QHP are permitted either to retain their marketplace coverage along with their APTCs or to transition into Medicaid coverage that will be considered MEC. The guidance states:

> An individual enrolled in a qualified health plan who becomes eligible for Medicaid coverage for pregnancy-related services that is minimum essential coverage, or for CHIP coverage based on pregnancy, is treated as eligible for minimum essential coverage under the Medicaid or CHIP coverage for purposes of the premium tax credit only if the individual enrolls in the coverage.[1]

[1] IRS Notice 2014-71, https://www.irs.gov/pub/irs-drop/n-14-71.pdf, clarifying that an enrollee in a QHP who becomes eligible for pregnancy Medicaid coverage that is considered MEC will only be considered eligible for MEC if they actually enroll in that coverage.

Further, if a woman actually enrolls in the Medicaid coverage she will thereby be ineligible for the marketplace APTCs or cost sharing reductions.[2]

Health coverage is particularly important during pregnancy and the postpartum period to avoid churn and preserve continuity of care. A woman should be able to choose the coverage that is best for her based on the benefits package, cost, plan choice, and provider network. Although pregnancy-related Medicaid coverage may be a better option for some women because of enhanced coverage with no cost-sharing, women should be able to choose between coverage options. We are concerned that as a result of misinformation or defects in IT enrollment systems, some women may have their marketplace coverage terminated and instead are automatically enrolled in Medicaid once they report their pregnancy as a life event. This is contrary to the aims of the ACA to ensure continuity of coverage and guidance issued by the Treasury and IRS clarifying that pregnant women have a choice of coverage options.

We recommend that the single streamlined application provide explicit information to pregnant women about their coverage options—including the choice to retain marketplace coverage and how to effectuate this with the current technology limitations—to avoid disruptions in coverage and care. Providing assisters and navigators clear directions as well as inserting language on the federal exchange as pop-up or help text informing women of their choice between maintaining QHP coverage or Medicaid eligibility can help accomplish this. We support the recommendations of the Center on Budget and Policy Priorities regarding text accompanying the question whether a consumer is pregnant.

III. Privacy

Since the application will ask for the Social Security numbers or immigration document numbers of all applicants, and the privacy statement includes acknowledgement that information may be checked against the Department of Homeland Security, we strongly recommend that language be included in this part stating that information provided to apply for health insurance will **not** be used for immigration purposes.

RECOMMENDATION: Include the following language in the privacy statement:

> ***We will keep all the information you provide private and secure as required by law. We will use it only to check if you are eligible for health insurance. Applying for health insurance or getting help with health insurance costs will not make you a "public charge"* and will not affect your immigration***

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf.

status or chances of becoming a lawful permanent resident (getting a "green card") on that basis. Applying for health benefits won't prevent you from becoming a citizen, as long as you tell the truth on the application.

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

III. Get Started

E. Contact Preferences

We strongly support continued collection of the preferred spoken language for the application contact. As we have recommended before, we also urge HHS to collect the language preferences for **all** applicants and not just the household contact. Our comments on this recommendation are below under section VII.

Further, the online application language selection allows for a drop-down box listing some of the most common languages and contains an option for "other." The "other" option is not fillable, however, and thus consumers who speak "other" languages, cannot complete the form. As a result, consumers who speak languages such as Punjabi are unable to note their correct language preference on the Marketplace application. This raises a number of issues, including the fact that accurate language preference is not being transmitted to insurers and is not being collected by the federal Marketplace. Without this information, we are concerned that the federal Marketplace is not able to meet its obligation under Section 1557.

V. Help Paying for Coverage

C. Income Screener

We appreciate having screening questions to ascertain whether a consumer likely should apply for financial assistance. However, the complexity of MAGI and household rules likely means that some individuals who are eligible for financial assistance may be screened out because they do not accurately understand who is in their household and what income counts. Thus, we recommend that HHS create an income calculator and provide a link from these questions to consumers who may have more complex family and income situations. A pop-up or help text could help direct consumers who may fall into these situations to the option to use the calculator to more accurately screen whether they should apply for financial assistance. We also recommend having an income calculator available for all consumers who apply for financial assistance since

many of them also have difficulties estimating their income, determining what income counts, and determining the accurate composition of their households.

VII. Tell us about each person

F. Race & ethnicity

We strongly support the collection of this data from consumers. Further, collection of this information is required by Section 4302 of the ACA. We would oppose any changes to collecting this data.

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

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

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

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

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

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

effective for data collection – if the Exchange collects this data and ensures its availability to others who need it, it can preclude multiple requests for the same information.

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

RECOMMENDATION: Move the race and ethnicity questions **above** "Is Person 1 applying for health insurance" so that it is collected from non-applicants as well as applicants. We also suggest that the request for data include an explanation of the reason. In testing done by the Health Research and Educational Trust, providing a rationale for collecting race, ethnicity and language based on equality provided the greatest response from patients to provide this data. We thus recommend an adapted version of this same language.

Language

Currently, the application only collects the preferred spoken language of the household contact. Language data should be collected from **all** applicants (and the parents/guardians of minor applicants) to ensure compliance with Sections 1557 and 4302 of the ACA as well as to ensure accurate data needed for language access planning.

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

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

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

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

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

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

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

We must improve on the collection of important demographic data through the single, streamlined application. We urge HHS to seize this opportunity and ensure comprehensive language data collection for the same reasons we support comprehensive language data collection.

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

VIII. More about this household

1. Disability Questions

The stated purpose of the two disability questions is to identify individuals who may meet disability-based eligibility criteria and be eligible for "traditional" Medicaid rather than expansion-based Medicaid. Yet we also believe collecting this information is important to identify individuals who are medically frail and, if eligible for Medicaid, would be exempt from enrolling in an Alternate Benefit Plan (ABP). Providing the context for these questions is important so that individuals understand that identifying as having a disability may result in receiving more tailored services at less cost.

We believe the current questions on disability and whether the applicant requires assistance with activities of daily living (ADLs) will not identify whether an applicant may be eligible for Medicaid on a basis other than MAGI or medically frail. Since the benchmark benefits available to newly eligible adults will likely be less robust than those in traditional Medicaid, is it important that applicants have a full opportunity to determine eligibility for the health insurance program that best suits their needs.

Moreover, some individuals who have chronic or serious medical conditions that would likely qualify them for Supplemental Security Income (SSI) or state disability criteria and thus eligible for Medicaid on the basis of disability may not identify self-identify as "having a disability" or limitations on their activities of daily living, particularly without knowing why these questions are being asked. Therefore, the questions should be appropriately tailored to identify those individuals.

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

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

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

The single streamlined application should incorporate appropriate screening for persons with disabilities consistent with the ACA and advances made in the development of survey questions to identify persons with disabilities. The screening is essential to ensure that individuals have access to the right care for their needs.

For many years, the federal health-focused surveys have included questions that allow the identification of disability using a set of questions based either on activity limitation

or functional limitation.[3] This provides a basis upon which to identify individuals with disabilities through survey questions, which can be incorporated into the single streamlined application.

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

We believe that CMS should include, at a minimum, the six questions on the ACS survey on the single, streamlined application. As an alternative, CMS should include explanatory text in the application and a link to additional information to help individuals ascertain how to answer this question.

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

> ***Needs help with activities of daily living though personal assistance services or a medical facility?***
>
> ***You may be eligible for another program that will better meet your needs if you answer yes to any of the questions below.***
>
> ***Do you have a physical, mental, or emotional, health condition that causes limitations in activities? ☐Yes ☐ No (if Yes, please skip the following six questions)***
>
> > ***1) Are you/is this person deaf or does he/she have serious difficulty hearing?***
> > ***2) Are you/is this person or does he/she have serious difficulty seeing even when wearing glasses?***

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

3) Because of a physical, mental, or emotional condition, do you/does this person have serious difficulty concentrating, remembering, or making decisions?
4) Do you/does this person have serious difficulty walking or climbing stairs?
5) Do you/does this person have difficulty dressing or bathing?
6) Because of a physical, mental, or emotional condition, do you/does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

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

RECOMMENDATION: Include the following:

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

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

11.-14. Foster Care

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

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

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

Additional Medicaid-related questions

We appreciate the inclusion of questions with regard to disability status and foster care to help identify individuals who may be eligible for traditional Medicaid so that they can obtain the complete eligibility determination. Yet many other individuals may also be eligible for "traditional" Medicaid and not adequately identified by the current application or sufficiently knowledgeable about Medicaid to apply directly to a state Medicaid agency. We suggest that HHS add additional help-text to help individuals identify if they may be eligible for "traditional" (as opposed to Expansion) Medicaid. This would include individuals who may be eligible based on a disability determination, Family Planning Services and Supplies (FPSS), through the Breast and Cervical Cancer Treatment Program (BCCTP), as medically needy, or other "traditional" Medicaid categories. For example, the application currently determines MAGI Medicaid eligibility for major categories— pregnant women, children up to age 19, parents and caretaker relatives, former foster children, and childless adults age 19-64. As it is currently structured, the application neither screens for applicants who might be eligible for other Medicaid categories nor does it provide sufficient information for applicants to determine independently how to obtain other available Medicaid coverage.

Many individuals are not aware that they could qualify for additional coverage options, and an adverse full-scope Medicaid determination will likely end their inquiry into public health insurance coverage options. This is because individuals who are not eligible for Medicaid but who might be eligible for FPSS coverage do not receive information about this possibility. While many of these individuals may be eligible for APTCs (and CSRs), some still find coverage unaffordable and will not enroll. Others may fall in the Medicaid gap and be left without available full-scope Medicaid or marketplace coverage. Ensuring that these individuals receive at least some coverage in is critical, and including this information in the application will further a goal of the Medicaid program and the ACA to provide individuals with these essential services.

To remedy this omission, the application should include pop-up text that informs applicants that even if they are not eligible for full-scope Medicaid, they may be available for additional "traditional" Medicaid categories for which the online application does not

screen. The pop-up should make clear that the online application only screens for certain Medicaid categories, and there are other pathways to eligibility. Finally, although the 2016 Eligibility Determination Notice (EDN) does not include information about these additional Medicaid categories, we recommended adding this information for 2017 and beyond.[4]

RECOMMENDATION: The single streamlined application should include both pop-up text and information language in the Eligibility Determination Notice that even if an applicant is not eligible for Medicaid, it is possible to qualify for other categories of services. We also recommend including a suggestion to contact the applicant's state Medicaid office for more information about receiving an eligibility determination. Further, we believe the Exchanges must ask sufficient questions and be prepared to assess eligibility for Medicare Savings Programs (QI-1, SLMB, QMB). To make such an assessment, HHS would need to identify an applicants' Medicare enrollment by Part, income, assets, and current MSP enrollment status. MSP programs are critical programs for older adults and persons with disabilities which are historically under-enrolled, and HHS should make an exerted effort to systemically identify and enroll these applicants.

IX. Income

As we mentioned above related to the income screening questions (V.C.), many individuals have significant difficulties answering the income questions. This may be due to a number of different circumstances including self-employment income, profit/loss from business income, seasonal/temporary employment, student loans or scholarships, veteran's benefits, unemployment benefits, etc. We strongly urge HHS to develop a consumer-facing income calculator that would help identify all potential sources of income and help individuals determine what to include (and exclude) from the actual application.

In particular, we recently identified a problem with consumers who wish to input income received once rather than monthly. Our understanding of this issue is that if a consumer enters one time only income (as his only income source), the application says the consumer's expected income is $0. In order to project the consumer's income to be equal to the one time only value, the consumer needs to select "No" when the application asks if $0 is the amount the consumer will make in 2016. This can be confusing because the one time only income value continues to appear as the value on various confirmation and review pages. However, without entering an income value in the second screen, the one-time income will not be included when APTC eligibility is

[4] https://marketplace.cms.gov/applications-and-forms/notices.html.

determined. Many consumers will be unaware of this and thus have their financial eligibility miscalculated which can affect the eligibility for and amount of tax credits received. And this is but one example of problems entering income we have heard about from assisters and consumers.

XI. APTC Program Questions

B. Health coverage (APTC Eligible)

The application asks if an individual is enrolled in Medicaid. We appreciate the notes that if an individual's Medicaid coverage is ending or is limited in scope that the individual should not check the box. However, determining whether one's Medicaid coverage is limited in scope can be difficult for many consumers who do not understand the intricacies of Medicaid. We suggest that additional information be provided via help text or a link outside of the application to determine if the coverage is limited. In particular, determining whether "medically needy" coverage is MEC is dependent on a number of factors including the scope of benefits and whether a spenddown is required. In addition, some states have limited scope pregnancy-related Medicaid coverage while others do not. We urge HHS to establish a centralized listing for consumers about how to determine if their Medicaid coverage is limited in scope and include lists of whether states' medically needy and pregnancy-related coverages should result in a "yes" or "no" answer to this question.

Collecting Sex, Sexual Identity and Sexual Orientation data

We support the comments from the Center for American Progress regarding collecting sex, sexual identity and sexual orientation data. To effectively address LGBT health disparities, including those affecting multiply disadvantaged groups such as LGBT communities of color, the applications outlined in CMS-10440 should clarify the existing sex question to be inclusive of transgender individuals. They should also begin collecting demographic data on sexual orientation on a voluntary basis, similar to the current collection of race and ethnicity data on these applications.
Models already exist for how data on sex (including gender identity) and sexual orientation can be collected on both the electronic and paper applications outlined in CMS-10440. Specifically, we recommend updating the current sex question to clarify what is being asked and to incorporate gender identity, which is an important component of sex. This approach will reduce the risk of identity verification failure for transgender applicants, ensure that the applications appropriately assess eligibility for benefits for all individuals who can become pregnant (which includes transgender men, who are individuals with a male gender identity who were assigned female at birth), and aid insurance carriers in addressing concerns of fraud related to claims for services that

appear to conflict with an individual's recorded sex. We also recommend adding a question about sexual orientation immediately after the questions about ethnicity and race. Like other commenters, we support the collection of race, ethnicity, and other demographic data from ***all*** applicants and non-applicants, not just from the primary point of contact for the application.

The sex question asked on all versions of the application presently has two answer options: "male" and "female." We recommend updating this question to the two-step question for sex (including gender identity). On both the online and paper applications, this question would replace the current sex question that is asked for each applicant immediately after the applicant's Social Security number. This question has two parts because many transgender individuals identify simply as men or women, meaning that their transgender status is only apparent through the difference between their gender identity and the sex that they were assigned at birth.

RECOMMENDATION: Include a question collecting sex and sex assigned at birth (immediately after the gender question) as follows:

What is your gender?

- *Female*
- *Male*
- *Transgender: Male to Female*
- *Transgender: Female to Male*

What is the sex listed on your original birth certificate?

- *Female*
- *Male*

We also recommend adding a question about sexual orientation in conjunction with the existing questions on race and ethnicity. Like these other demographic questions, sexual orientation should be optional information gathered solely to help ensure that everyone has the same access to coverage.

RECOMMENDATION: Collect sexual orientation data immediately following the optional questions on race and ethnicity as follows:

Do you consider yourself to be:

- *Straight or heterosexual*
- *Gay or lesbian*
- *Bisexual*
- *Other*

Collecting sexual orientation and sex (including gender identity) data in the manner recommended above has many purposes. Among other uses, it will broadly promote better understanding of consumers from diverse backgrounds; help monitor compliance with LGBT-inclusive nondiscrimination requirements; and facilitate the functioning of operations related to outreach and consumer assistance.

ATTACHMENT B, C, D – PAPER APPLICATIONS

We recommend incorporating all of the recommendations above addressing issues with the electronic application into the paper application.