Planned Parenthood Federation of America

Planned Parenthood Action Fund

February 1, 2016

VIA ELECTRONIC TRANSMISSION

William N. Parham, III
Director, Paperwork Reduction Staff
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Attention: CMS-10440/OMB Control Number 0938–1191
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 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 Mr. Parham,

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments on the Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and Children's Health Insurance Program Agencies draft applications, published on December 2, 2015 at 80 Fed. Reg. 75463 *et seq*. As a trusted women's health care provider and advocate, Planned Parenthood supports the Department of Health and Human Services' ("Department's") commitment to seeking input from a cross section of stakeholders as it works to improve the single, streamlined application and ensure that all individuals receive the health coverage they are entitled to under the Affordable Care Act.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 700 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for STDS, and other essential care to nearly three million patients. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL). We also provide abortion services and ensure that women have accurate information about all of their options.

Since the first open enrollment period, Planned Parenthood has participated in enrollment activities. Three of our affiliates were awarded Navigator grants in 2015. Additional affiliates, and their staff, assist in enrollment activities either through an official role as an In-Person Assister or Certified Application Counselor or by partnering with community groups that help consumers enroll. Moreover, Planned Parenthood provides

patients and community members with information about the Affordable Care Act to ensure that individuals understand the benefits of the law and where to apply for coverage.

I. Application Questions

We appreciate the Department's efforts to create an application that is user-friendly and consumer-focused. Specifically, we commend the Department for crafting an adaptive online application so that consumers can complete the questions that are only relevant for them and have a more simplified, expedient enrollment process. We encourage the Department to balance any revisions to the application with the overarching goal of a streamlined and consumer-friendly application process.

A. *The application should screen and determine eligibility for limited-scope Medicaid family planning programs.*

Many low-income individuals ineligible for comprehensive Medicaid coverage may be eligible for limited-scope Medicaid family planning programs. Currently, nine states that have not expanded coverage for full-scope Medicaid—all of which are in the Federally-facilitated Marketplace (FFM)—provide family planning-only coverage: Alabama, Florida, Georgia, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, and Virginia.[1] In these states, low-income childless non-pregnant adults who apply for coverage will be informed that they are not eligible for Medicaid coverage or premium tax credits to help purchase Marketplace plans. These individuals may believe that they are ineligible for any coverage, when the reality is that they could receive limited-scope family planning coverage.

While family planning coverage is not comprehensive, it provides access to critical preventive health care, such as well-woman exams, birth control, and testing and treatment for sexually transmitted infections for otherwise uninsured individuals. In fact, the services that family planning expansions offer are the services that women of reproductive age are most likely to report needing access to.[2] Indeed, family planning access is tied to improved maternal and infant health outcomes. Improving access to Medicaid-covered family planning services also saves money, as every dollar spent on publicly-funded contraception saves more than $7 in other costs.[3]

Notably, extending the FFM application to determine eligibility for family planning-only programs would not require any additional information from applicants, as the application already collects the data needed to ascertain eligibility for family planning-only programs (e.g., income, family size, pregnancy). Moreover, the systems needed to determine eligibility for family planning-only coverage are already built in, given that family planning-only program income eligibility levels are often identical to income eligibility levels for pregnancy. Extending the FFM single, streamlined application to screen for and determine eligibility for family planning-only coverage is an easy and effective way to ensure that more uninsured, low-income individuals receive the coverage to which they are entitled and have access to essential preventive health care.

B. *The Department should make sure questions related to pregnancy are accurate and neutral.*

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[1] Wisconsin also operates a limited-scope Medicaid family planning program. However, Wisconsin provides Medicaid coverage to childless non-pregnant adults who have incomes up to 100 percent FPL.

[2] Perry Undem Research & Communication, "Women & OB/GYN providers," *Planned Parenthood Federation of America*, November 2013

[3] Frost, JJ, et al., *Return on investment: A fuller assessment of the benefits and cost savings of the US publicly funded family planning program*, *The Milbank Quarterly*, (Oct.14, 2014), *available at* http://www.guttmacher.org/pubs/journals/MQ-Frost_1468-0009.12080.pdf.

We thank the Department for including questions in paper and online applications to determine if an applicant is pregnant and how many babies are expected during the pregnancy. Both of those questions help assess eligibility for Medicaid coverage. As the Department knows, Medicaid is an essential source of maternity care for low-income women, enabling them to access the services they need for healthy pregnancies and better health outcomes for both them and their babies.

Some text of question 10 in Section VIII of the online application uses the term "unborn baby." The exact text reads "(Display item if an applicant was indicated in item 9 or a non-applicant was indicated in item 9 in a state that has taken up the option to count more than one unborn baby in a Medicaid household size in case there is a pregnant non-applicant.)" We assume that this text is not displayed to the consumer and that it is merely used as a prompt in the adaptive online application. Nevertheless, it is critical that every component of the HealthCare.Gov platform use correct terminology.

The application should instead mimic language from federal regulations regarding household size for pregnant women. For example, revised text could read "(Display item if an applicant was indicated in item 9 or a non-applicant was indicated in item 9 in a state that has taken up the option to count a pregnant woman's household to include the number of children she is expected to deliver in case there is a pregnant non-applicant.)" This revision accurately reflects the law and models appropriate language when referring to a woman's pregnancy.

C. *We encourage the Department to incorporate an additional optional data collection question on sexual orientation and clarify application questions that require individuals to identify their sex.*

The applications currently include optional questions to collect data on race and ethnicity. In addition, applicants are asked to indicate their sex and primary language spoken. These questions, taken together, help the Department and states understand who is applying for coverage and who has obtained coverage, which helps inform outreach efforts. The Department could have a more comprehensive understanding of ACA outreach and enrollment efforts if the application also included an optional data collection regarding sexual orientation. Similar to the optional data collection questions on race and ethnicity, if the Department includes an optional data collection question on sexual orientation, we urge the Department to make clear that applicants do not need to answer the question to proceed with their application, that the questions are to glean information solely for demographic data purposes, and that personally identifiable information will not be shared.

It has also come to our attention that HealthCare.Gov requires consumers to indicate their sex before allowing them to browse the plans offered on the Marketplace. We assume that this question is intended for data collection purposes, despite the fact that it is not optional. To ensure that HealthCare.Gov is as user-friendly as possible and that consumers can browse plans before they apply for coverage, we ask the Department to either remove this question entirely or make it optional. If the Department makes the question optional, we ask that the Department include the explanation it provides for the other optional data collection questions.

Furthermore, consumers who are transgender have also noted confusion and apprehension when asked to indicate their sex on their application. In particular, they are unclear on whether their answer should reflect their gender identity or official government documents (e.g., birth certificate), and if inconsistency in their answer will restrict their ability to enroll in coverage. Ideally, the application would provide a two-step question regarding gender and sex. The first question would ask an applicant to identify her or his gender, which choices including male, female, transgender: male to female, and transgender: female to male. The second question would ask an applicant to identify the sex listed on her or his original birth certificate.

This two-step process would not only provide for a more accommodating application process for LGBT individuals, it would also ensure that the complex adaptive application does not pose challenges for transgender applicants. For example, the identity verification process could more accurately match records with an applicant who is transgender and is in the process of changing their sex on official documents if the applicant is able to provide information about their gender identity in addition to their sex assigned at birth. Additionally, if the adaptive application triggered pregnancy questions based on female sex at birth, the application would not inadvertently skip over pregnant transgender men (men who were assigned female at birth). This would ensure that all low-income pregnant individuals, regardless of their current gender identity, are able to be assessed for Medicaid eligibility and gain critical coverage of pregnancy-related services.

At a minimum, the Department should incorporate explanatory text indicating how individuals should identify their sex on the application. This additional clarification will, at the very least, provide clear instructions for transgender applicants and minimize enrollment delays for transgender individuals.

D. *The application should provide additional information for applicants who have been or are affected by domestic violence or spousal abandonment.*

Recent federal regulations permit individuals who are domestic violence survivors or abandoned spouses (e.g., cannot locate their spouse after due diligence) to enroll in their own health plan separate from their spouse and are not required to include their spouse's income when applying for premium tax credits in the Marketplace. The general rule is that married couples must file taxes jointly with their spouse to access Marketplace subsidies. But, individuals experiencing domestic violence or spousal abandonment are exempt from this rule and allowed to file taxes separately from their spouse and may say they are "unmarried" on the single, streamlined application. However, this important option is not clarified in the application. Although information about this important exception is available on Healthcare.gov, this information is not clear as part of the application process. It is important that an applicant affected by domestic violence or is an abandoned spouse be informed of this important option. To this end, we recommend that the application note the exception and direct consumers to the page on HealthCare.gov providing information on how to take advantage of this option when applying for coverage.

E. *The application should eliminate unnecessary questions related to immigration status and affirm privacy protections for non-citizen applicants.*

Immigrants face unique challenges when accessing health care programs and may require special attention to prevent discrimination from occurring against them. Unnecessary questions related to a person's immigration status may produce a chilling effect and deter eligible immigrants from applying for health coverage. As the Department continues to improve its online and paper applications, we urge that the applications ask only those questions related to immigration status that are necessary to verify the eligibility of those consumers applying for coverage. In particular, the application should not ask unnecessary questions related to immigration status for individuals applying on behalf of another person in his or her family.

In addition, it is important that consumers understand that the information they provide will not be used against them or other family members for immigration enforcement. In 2013, U.S. Customs and Immigration Enforcement (ICE) issued a memorandum clarifying that any information provided by consumers in the context of coverage for the Marketplaces, Medicaid, CHIP, and Basic Health Plans, would not be used for immigration enforcement purposes. To ensure immigrant families better understand their privacy protections and feel confident applying for coverage, we urge the Department to clearly state in the paper and online applications that information will not be shared with ICE or used for immigration enforcement purposes.

II. Additional Comments

A. *The Department should not require consumers who become pregnant mid-coverage year to re-apply for coverage. In addition, the Department should make sure that any transitions in coverage for pregnant women are seamless and do not result in periods of uninsurance.*

We are concerned that Marketplaces may be inappropriately terminating a woman's coverage upon notification of pregnancy. Apparently, women who become pregnant during the coverage year and notify the Marketplace about their pregnancy are often faced with the termination of their existing health coverage and being forced to re-apply for coverage. It is possible that some Marketplaces are trying to make sure that lower-income women can enroll in Medicaid coverage, thus enabling low-income pregnant women to receive pregnancy-related services without cost. However, due to lag times in enrollment, these Marketplace actions merely result in a pregnant woman experiencing a gap in coverage – and at a time when she needs ongoing, routine, and timely health care services.

There is no requirement in federal law that a woman who qualifies for Medicaid enroll in Medicaid coverage. Likewise, there is there a requirement that a woman be re-determined for eligibility upon notification of her pregnancy. However, because Medicaid household size for pregnant women includes the pregnant woman plus one or the number of children she is expected to deliver, a woman who becomes pregnant mid-year could be seen as having a change of income and choose to be assessed for Medicaid eligibility. If she chooses to have an eligibility re-determination and is determined to be eligible for Medicaid, she may then choose to either enroll in Medicaid or remain in her Marketplace plan (which may result in a return of federal premium tax credits and cost-sharing reductions payment via tax filing reconciliation).

As the Department seeks to improve the application and enrollment process, we urge the Department to make clear to Marketplaces that women who become pregnant mid-coverage year must be allowed the choice of whether or not to re-determine eligibility. To ensure that a woman is making an informed decision, the Marketplace must provide each woman information about what the re-determination process entails, the costs she may incur by maintaining or switching coverage, and the benefits and provider networks she would be afforded under Medicaid. Additionally, Marketplaces must be instructed not to terminate QHP coverage until the woman has been enrolled in Medicaid so that women do not experience a gap in coverage and have a seamless enrollment experience.

Notably, this approach is similar to what exists within the Medicaid program. Women enrolled in the new adult (Medicaid expansion) group who later become pregnant may choose to remain in the new adult group or transfer to the pregnant woman group. This policy recognizes that transfer of coverage could disrupt continuity of care and loss of a trusted provider in a specific network. It also potentially reduces administrative complexities and costs.

It is important that pregnant women receive the health coverage they are entitled to under the law. Equally important, pregnant women must have access to timely services from providers they trust. Allowing pregnant women the choice to re-assess eligibility mid-coverage year and providing seamless transitions of coverage will ensure that pregnant women maintain coverage and have access the critical health care services they need.

B. *The Department should continue its language access services and also make sure that health coverage information is provided in English in addition to the applicant's primary language.*

We commend the Department's efforts to establish an application process that can be tailored to individual applicants, including preferred language. We also appreciate that HealthCare.Gov has a Spanish translation site and that the call center has a language line. As the Department works to improve the application and the application process, we encourage the Department to continue language access services and ensure that written materials are readily available in languages other than English and Spanish. Having easily accessible materials in multiple languages ensures that all consumers can meaningfully engage the application and feel comfortable navigating the enrollment process.

In addition, any information about eligibility determinations needs to be provided both in the applicant's preferred language and English. Navigators and In-Person Assisters may not be fluent in the applicant's preferred language and unable to assist them in deciphering their eligibility determination if an English translation is not provided. Similarly, the Spanish-translation HealthCare.Gov site should make sure that eligibility determinations are provided in Spanish as well as English. Currently, information about an applicant's eligibility determination only displays in English.

C. *The application and enrollment process should include alternative mechanisms to verify identification.*

The current enrollment process requires consumers to successfully complete a remote identity proofing process (RIDP) before being able to submit an application for coverage. The RIDP process verifies identity using a consumer's credit history, checked against records maintained by the credit bureau, Experian. While this type of RIDP may work for a majority of consumers, it is not an effective way to verify identity for individuals with little or no credit history. Immigrant consumers, in particular, are less likely to have the type of credit history for successful identification verification. As a result, many are delayed from enrolling or are unable to complete their application. We urge HHS to add greater flexibility to the identification verification process to allow consumers with little credit history to obtain coverage for which they are eligible.

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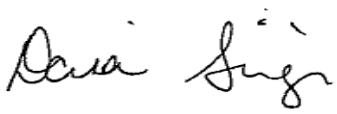
Thank you for the opportunity to comment on the model application. If you have any questions, please do not hesitate to contact me at 202-973-4800.

Respectfully submitted,



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