August 31, 2012

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
U.S. Department of Health and Human Services
Attn: Document Identifier: CMS-10440
Room C4-26-005
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS 10440, Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Health Exchanges, Medicaid and Children's Health Insurance Program Agencies

Dear Sir or Madam:

The Center for Law and Social Policy (CLASP) is a national organization that develops and advocates for policies at the federal, state and local levels that improve the lives of low-income people.

We appreciate this opportunity to comment on the proposed data elements for the single, streamlined application. With the implementation of the Affordable Care Act (ACA), it is critical to ensure that low-income individuals who are eligible for Medicaid, CHIP, Advanced Premium Tax Credits and cost-sharing assistance are found eligible for relevant subsidies and programs. This streamlined application is a first step to identify individuals and their eligibility for these vital health programs and ensure a seamless eligibility process. As such, its design is critical in meeting these goals.

General Comments

I. *Simplicity*

It is important that the application, whether it is online, on paper, or by telephone, uses plain and common language asking only questions that are relevant to determining an individual's eligibility. In instances where technical language must be used, it should be further defined or explained in plain language. The final application should also be consumer-tested for readability and comprehension. The application should also include information about how to obtain assistance in completing the application.

II. *Clarity of requirements and consequences*

It is important that the application, whether it be online, on paper or by telephone, clearly explains which questions are optional and which are required for submission. This should be laid out in the beginning of the application as well as indicated throughout the application where information is required or is optional. The application should also clearly explain what consumers should do if they

do not have the answer to a required question, or if they only have an approximation, and what the consequences of answering that question inaccurately or incorrectly are. If consumers are encouraged to provide approximate answers, the signature or submission statement should reflect that guidance, and should not require consumers to make false attestations of complete accuracy.

III. Privacy

We support the inclusion of a privacy statement at the beginning of the application, whether it is online, on paper or by telephone. The privacy statement should provide reassuring messages about the protection of privacy and that information will only be used to check eligibility for health insurance.

IV. Accessibility

The application should be available in multiple languages, meeting the access standards for people with limited English proficiency. In the online and paper forms, contact information for in-language assistance should be prominently listed. In all forms, the application should also meet the rules ensuring equal access to persons with disabilities.

V. Application Access

Applicants should be able to save their progress and return to an application at a later time. Consumers may not have access to all the required information at the time they begin the application, or may discover that they require application assistance, and should not lose their work to that point. Consumers should also be able to switch between application mechanisms along the way. For example, an applicant should be able to start their application on paper, fill in the information online, stop, and continue completing the application by telephone or in person at a later time. The submission of a partially completed application, regardless of missing information to establish an official application date, should trigger follow up procedures to assist the applicant in completing their application.

VI. Alternative Applications

States are allowed to develop their own applications with Secretary approval. In reviewing these applications, the Secretary should ensure that the standards in the model application developed by HHS applies to the state application being considered, including plain language use and requiring states to collect the same demographic data to ensure consistency. HHS must also ensure that the state consults with consumers and representatives from low-income and underserved communities in the development and testing of the application.

Baseline Applicant Information

I. Household Contact Information

It should be clearly indicated which individuals need to be listed in this section, whether the application is seeking to identify a person in the household or if it can be someone outside of the applicant household who has been designated as an authorized representative. The application should also make clear whether the address requested is a mailing address or legal residence, and what individuals who are homeless or lack a phone number should provide.

II. Authorized Representative

There should be clear instructions on the differences between a household contact and an authorized representative. The roles and responsibilities of an authorized representative and its

limitations to make health care decisions, should be clearly defined, and should also include what potential consequences are for the applicant or representative if there is any misrepresentation.

III. *Applicant/Non-Applicant Information*

HHS should clearly highlight where information is optional for non-applicants and/or applicants and what the information will be used for. This is particularly critical for SSNs; application instructions should explain what should be entered for household members who do not have a SSN.

Income and Additional Information

Questions in this section should be straight forward and require reporting only what is available to the applicant such as using information from their paystubs, regardless of how frequently they are paid. Additional guidance on which wage information is required and referencing a particular location on a commonly used document find this information (i.e., on a pay stub, a simple tax form, etc.) may be particularly helpful. It is also important to provide strong guidance and support for those who may not be paid regularly or in a typical fashion, such as those who work for multiple employers or those with irregular employment.

Information on the importance of income reporting and what it will be used for is also needed.

I. *Projected Annual Income*

We recommend that "Projected Annual Income" come after "Current/Monthly Income," since it may be easier for some to calculate annual income after determining their monthly income. In addition, we support the option for "don't know," given that many individuals may not be able to provide this information. Clarification should also provide applicants with information on what happens if income ends up being higher or lower than projected and that selecting "don't know" will not affect their eligibility.

II. *Current/Monthly Income*

Guidance on how to calculate a monthly income should be provided, referencing common documents such as an applicant's pay stub and the frequency of payment. We support the flexibility to skip this question, however, information should be provided on how this may or may not impact an applicant's determination.

III. *Discrepancies*

We recommend that HHS avoid the use of the word, "discrepancies," in this section and use a simpler terminology for the application. For example, "changes," may be a better word choice for this element and may be less intimidating for applicants.

In addition, HHS should ensure that simple language be used to collect information on this element. Questions should include asking if applicants have more than one employer, and whether applicants' paychecks vary across pay period.

While we support the goal of identifying any reasons why self-reported information may not match information in other databases, we are concerned that individuals in hourly jobs, whose earnings often vary significantly from week to week, should not be forced to provide excessive amounts of information at this stage in the process. Applicants should have the opportunity to simply flag that their income varies, and request that the agency follow up later if the variation affects their eligibility or options. Applicants should have the opportunity to provide explanations on why a

discrepancy exists and clear information should be prominently available about how a discrepancy may or may not affect their health insurance eligibility.

IV. Additional Information

Recipients are required to report any changes, including changes in residency, to the health insurance affordability program (which should be clearly explained in the notice of eligibility and determination). Therefore, there isn't a need for applicants or non-applicants to provide an intended change of residency.

Program-Specific Questions

I. Exchange

We have significant concerns about a requirement to collect employer information from applicants who may not readily have access to them. We recommend that this information be optional for applicants to complete. Without this information, consumers could still be informed of their Medicaid eligibility and told that they are potentially eligible for Exchange subsidies depending on their employer-provided benefits.

Clear directions should be provided on whether applicants are expected to skip questions to information they don't readily have access to, or if an estimate would be adequate.

We recommend that applicants should only be asked basic questions pertaining to their employer such as employer name, contact information and hours per week and whether or not they receive any coverage through them. To the extent that additional information is required, employers should be required to provide employees each year with a report that clearly provides the needed information, including EIN, offer of health coverage, name of lowest cost plan, employee contribution and frequency, and minimum value standard.

The regulations state that exchanges must first determine or assess eligibility for Medicaid prior to determining eligibility for APTCs. Therefore, applicants should not be asked to indicate or determine whether they are eligible for other coverage, as this should be determined by the exchange.

II. Medicaid

Information on past medical expenses do not affect an applicant's eligibility, and this should be relayed in this section. In addition, information about how this information will help applicants should also be included. Applicants should only be asked to indicate whether or not they have incurred any recent medical expenses through a simple checkbox. Additional details needed should occur post-eligibility through follow up.

The existence of an absent parent is not relevant to an applicant's eligibility and in some cases, asking such a question may be a barrier to enrollment. Parents receiving Medicaid are required to cooperate with child support enforcement, but this can be reserved as a follow up question post eligibility. If the question about an absent parent is retained, the application should provide an explanation as to what this information will be used for and allow an option to opt out if the applicant believes that identifying an absent parent will cause harm to themselves or their family.

Confirmation and Eligibility Determination

I. *Application Summary*

We strongly support the ability of applicants to review and make changes to their applications throughout the application process and providing an application summary prior to submission. Applicants should have the ability to save and print a copy of their application regardless of the method they are using to apply—in person, by telephone, on-line, or through the paper application.

II. *Rights and Responsibilities & Signatures*

We recommend that the rights and responsibilities be communicated in clear and simple language at the beginning of the application. This should include information on what data is being sought in the application, how data will be used, and any consequences of data entered incorrectly, inaccurately or if the application is incomplete. The rights and responsibilities of the various roles (applicant, non-applicant, household contact, authorized representative, navigator, etc.) should be explained in this section.

In addition, clear and simple directions and contact information should be provided on how to appeal the agency's decision as well as file a complaint if they believe they have been discriminated against. A clear and strong statement of civil rights protections should also be included here.

III. *Determination and Notices*

Households should receive a full and complete eligibility notice, regardless of whether or not the members are all eligible for the same program. The notice should clearly detail what each family member is eligible for and provide the basis behind the determination. If family members are split between various programs, an explanation should be provided. Additional verification, documentation or information needed should be listed, identifying which information is needed for which family member. Contact information on who to contact or how to provide additional information needed should also be provided. All notices should re-iterate the right to appeal an eligibility decision and information on how to do so.

The option for an applicant to withdraw a Medicaid application is highly confusing and should be re-visited for necessity. If the option remains, clear information needs to be provided to the applicant as to what the risks, and possible benefits, are for making such a decision. Contact information and assistance should be provided for applicants who are considering this option who may have questions. In addition, applicants should be allowed to restore their application and preserve their initial application date if they determine it was withdrawn in error at a later time.

HHS should also consider allowing Exchanges to suggest Medicaid withdrawal only to those applicants whose income is above a certain threshold who report no medical expenses or potential disability making it highly unlikely they are eligible for the other programs.

Qualified Health Plan Enrollment

I. *Plan Selection and Confirmation*

Applicants should be given adequate information in order to make an informed choice of plans. Applicants should be clearly informed on where and how they can access additional resources in helping them understand the various options available to them. These resources should be available in plain language and be accessible in-person, on-line, by mail and by telephone.

II. Amount of APTC Applied Toward Premium

HHS should detail, in plain language, how applicants can determine how much of the APTC they wish to apply towards the premium. It is essential to re-iterate the implications of this decision, and the impact that an income change may or may not affect this decision.

We appreciate this opportunity to comment on the data elements to the streamlined application which will have a significant impact on improving health insurance coverage for low-income individuals across the country. We hope that HHS will take our comments into consideration and welcome any questions or comments you may have.

Sincerely,

Helly Lee
Senior Policy Analyst