



June 7, 2011

*By electronic mail*

Honorable Teresa Miller  
Chair, Consumer Information (B) Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street,  
Kansas City, MO 64108

***Re: AHIP's Comments on the June 2<sup>nd</sup> Request for Public Comments on the Subgroup's Uniform Enrollment Form Draft Letter***

Dear Administrator Miller:

I write on behalf of America's Health Insurance Plans (AHIP), the nation's trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality and innovation.

We appreciate the work that your Subgroup has invested in this project and we also appreciate the opportunity to provide comments on your draft letter.

**The Draft Letter Should Focus More on Criteria for the Design of the Enrollment Form and an Effective and Efficient Enrollment Process and Less on Exchange Design Issues.**

We wish to recommend that the Subgroup focus its efforts, and expand its technical support, to address the specific issues pertaining to the enrollment process and to build upon current effective and efficient industry capabilities, and the current work of Health and Human Services (HHS) such as that pertaining to HIPAA 834 transaction standards for enrollment.

We are concerned that the draft letter inappropriately focuses upon Exchange design issues, such as focusing on such suggestions as the creation of a transparent and a consumer friendly experience, and gives insufficient attention to the significant issues pertaining to the application process, including support for electronic data capture and transmittal, as well as more technical issues, such as the transference of written application materials to electronic media for transmission to carriers.



In addition, while we recognize the significant time constraints within which the Subgroup is attempting to provide written criteria to the Secretary of Health and Human Services (the Secretary), we wish to convey that your Subgroup has provided insufficient time to enable our members to adequately review the host of enrollment operational issues that the Secretary will necessary have to address as HHS creates its intended single streamlined eligibility and enrollment process to meet the requirements of Section 1413 of the Accountable Care Act (ACA). We believe these requirements should be addressed within your written criteria submittal.

**Expand the Scope of the Subgroup's Draft Letter to Include Membership Maintenance.**

The draft letter addresses initial enrollment activities and appears silent on the equally important issue of membership maintenance. We recommend that the Subgroup expand its analysis of the enrollment process to include providing criteria for membership maintenance consistent with the criteria for initial enrollment.

**Other Matters.** The draft letter's criteria appear to refer to more than one form under the second paragraph on page two. We raise the question of whether it an assumption of the Subgroup that the Individual Exchange will have different forms for different purposes, i.e., separate individual applications and SHOP applications, or is the draft letter merely referring to a part of a form, such as specific eligibility questions.

Paragraphs three and five of the "Minimize Requirements..." Section may unrealistically limit the information needed to confirm eligibility for public programs. We remain concerned that the idea of a single, accurate question to "confirm ineligibility" remains unproved.

Although the draft letter addresses the application form, the criteria should recognize that individuals will need assistance throughout the enrollment process. Eligibility determination and / or enrollments may not be completed at one time. It may take several iterations. The form drafters should also recognize that the process may be interrupted while assistance is sought thereby requiring the capability to save the in-process application and revisit the incomplete application once the necessary information is available.

We support the concerns raised in the draft letter regarding consumers' expectations of financial privacy in instances where the application and verification process may require applicants to disclose spousal income and family financial information to employers. We wish to recommend that the Subgroup continue to review these issues concerning their potential impact upon a coverage applications and eligibility verification to ensure that only necessary information is required in coverage application process.

June 7, 2011  
Page 3



With regard to electronic transmissions of data, we wish to suggest that the draft letter consider criteria requiring Exchanges enter all the information onto an electronic form and transmit the information to the health plans electronically. Transferring the enrollment information between an Exchange and all the health plans in a variety of forms will increase costs and the likelihood of mistakes. Administratively, it would be more cost-effective and better for the plans, the enrollees and the Exchange if the Exchange took on the responsibility to enter enrollment information into an electronic form and transfer it to the plans electronically.

Finally, while we acknowledge the elimination of medical questions from eligibility determination, we believe that the enrollment process may benefit from questions on health status which would be asked solely for the purpose of case management assignment. We believe that both the efficiency and effectiveness of the process could be improved by including questions for this limited purpose as part of the application process, while the applicant will be relieved from having to be asked subsequently for this information.

We appreciate your consideration of our comments, and if you have any questions, please contact me at (202) 861-1476 or [mmitchell@ahip.org](mailto:mmitchell@ahip.org).

Sincerely,

A handwritten signature in black ink that reads "Mitchell, Jr." in a cursive script.

Martin L. Mitchell, Jr.  
Director, Product Policy



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

***By Electronic Mail***

June 7, 2011

Administrator Teresa D. Miller  
Chair, Consumer Information (B) Subgroup  
c/o National Association of Insurance Commissioners  
444 North Capitol Street, N.W., Suite 701  
Washington, D.C. 20001

Attention: Jane Sung and Jennifer Cook (NAIC)

**Re: NAIC Draft Recommendations to HHS and DOL on an Exchange Enrollment Form**

Dear Administrator Miller:

The Blue Cross and Blue Shield Association (“BCBSA”) appreciates the opportunity to provide comments to the National Association of Insurance Commissioners’ (“NAIC”) Consumer Information (B) Subgroup regarding the recently released draft comment letter to the U.S. Departments of Health and Human Services (“HHS”) and Department of Labor (“DOL”) on the criteria for enrollment into exchanges. BCBSA is a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for nearly 98 million members -- one-in-three Americans.

The draft letter identifies many important issues that should be considered by HHS as they develop criteria for exchange eligibility and enrollment. BCBSA recognizes that the letter is not intended to represent a final exhaustive list of issues for the Departments to consider.

However, we are concerned that the letter does not focus on the specific requirements for enrollment in a qualified health plan, and therefore does not include a recommendation to use existing Health Insurance Portability and Accountability Act (HIPAA) adopted transaction standards to facilitate consumer enrollment.

Our specific recommendations are as follows:

**1. Clarify that HHS Should Adopt the HHS Advisory Committees Recommendation to Use the HIPAA Standard 834 Enrollment Form**

The draft letter refers to the requirements in Section 1561 of the Affordable Care Act (ACA) for HHS, in consultation with the Health Information Technology (HIT) Policy and the HIT Standards advisory committees to develop standards to facilitate electronic enrollment of individuals in Federal and State health and human services programs.

The draft includes language from the HIT committees' recommendations and a link to their recommendations. However, the draft letter does not recommend use of the HIPAA 834 transaction standard for enrollment as recommended by the HIT committees.

As requirements for exchanges are established, it will be important for states to ensure an exchange is capable of enrolling millions of individuals and employees by 2014. An exchange should leverage existing processes and standards to ensure that coverage is in place for these individuals on day one. Consistent with the HIT advisory committees' recommendations, it would be most practical to leverage existing, widely-used HIPAA transaction standards (e.g., HIPAA 834, 270, 271) to send and respond to eligibility queries, as well as transmit enrollment data between public and private insurance programs.

Specifically, recommendation 4.1 of the "Patient Protection and Affordable Care Act Section 1561 Recommendations" says:

"Recommendation 4.1: We recommend using existing Health Insurance Portability and Accountability Act (HIPAA) adopted transaction standards (e.g., ASC X12N 834, ASC X12N 270, ASC X12N 271) to facilitate transfer of consumer eligibility, enrollment, and disenrollment information between Affordable Care Act health insurance coverage options (including Medicaid and CHIP), public/private health plans and other health and human service programs such as SNAP and TANF.

This recommendation supplements the existing requirement that electronic transactions constituting "covered transactions" under HIPAA comply with adopted HIPAA transaction standards."

We recommend revising the paragraph at the bottom of page 4 as follows:

**Collect Appropriate Information from Enrollees:** The information collected for enrollment into qualified health plans should be based on widely-used common standards so that health plans can ensure proper enrollment and transfer of information between public and private insurance programs. Since 2003, standard HIPAA transactions have been used to enroll consumers into public and private health coverage programs. Section 1561 of PPACA requires the development of standards to facilitate electronic enrollment, ~~and more information on these recommendations can be found at~~

We recommend that the form for enrollment into a qualified health plan through an exchange use existing HIPAA adopted transaction standards in the HIPAA 834. This will facilitate an enrollment process that is consistent with the HHS Health Information Technology (HIT) Policy and the HIT Standards advisory committees' recommendation. Their recommendation is based on offering seamless integration between private and public insurance options.  
<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161>

## **2. The Recommendations Should Focus on the NAIC Requirement in the ACA**

Although the Affordable Care Act (ACA) requires NAIC to provide input on the form for enrollment into a qualified health plan (QHP) through an exchange, the recommendations exceed the scope of this requirement.

ACA Section 1311(c)(1)(F) requires states to utilize a uniform enrollment form for enrolling individuals and employers into QHPs that takes into account NAIC criteria. However, the letter seeks to address multiple issues associated with the ACA's requirements for a streamlined eligibility and enrollment process under Section 1413. These recommendations would also apply to the overall design of the exchange eligibility and enrollment processes for all consumers (including Medicaid and CHIP enrollees), not just the individuals who will be enrolling into a qualified health plan.

The letter should solely focus on the necessary elements for individual and employee enrollment in a qualified health plan under Section 1311(c)(1)(F). If the recommendations related to streamlined eligibility under Section 1413 are retained, the sections of the letter addressing these issues should be presented separately from the Section 1311(c)(1)(F) issues.

### **3. Recommend Electronic Transmission of Data Between Exchanges and Health Plans**

The draft letter acknowledges that individuals will be able to continue to complete enrollment online, in person, by mail, or by telephone. However, the letter does not speak to how exchanges will submit enrollment information to qualified health plans under these various mechanisms.

Item 2 under the heading "Collect Appropriate Information for Health Plan Enrollment" should be removed or strengthened to say that all paper applications will be converted to an electronic format by an exchange. This will ensure that the business model of an exchange is designed to support efficient operations for public and private health plans and consumers by avoiding a potentially confusing three-way conversation among the consumer, the health plan and the Exchange in order to resolve issues that will inevitably arise for some consumers during a paper application process.

Specifically, we recommend strengthening the recommendation as follows:

**~~Consider How Non-Transfer Electronic Information Will Be Transferred to Health Plans:~~**

Individuals will be able to continue to complete enrollment online, in person, by mail, or by telephone. As exchanges are being implemented, the Departments and States should consider the process by which health plans will receive the submitted information from non-electronic submissions, and require that exchanges convert any non-electronic applications into an electronic format and send to health plans through the HIPAA 834 standard enrollment form.

### **4. Clarify Operational Responsibilities for Enrollment Applications**

While we recommend that the letter should solely focus on the necessary elements for enrollment in a qualified health plan, if other recommendations are maintained, we recommend that the letter also advise HHS on the following operational responsibilities:

**DEVELOP EXCHANGE ELIGIBILITY AND ENROLLMENT OPERATIONAL REQUIREMENTS:** The Departments should consider the operational requirements related to eligibility and enrollment, including:

**Application:** Applications for exchange coverage will need to be verified to ensure the information is complete and the applicant is eligible for enrollment in the selected option. Exchanges should be designed to collect and store applicant information. Processes should be developed to prevent duplication of applicants. Further, applicants will want to know how to check the status of an application.

**Enrollment:** Consumers will need to know how they will receive confirmation of enrollment and where to go for accessing future information and services.

**Eligibility Changes:** Consumers will need to know how to communicate any post-enrollment changes in status that affect eligibility such as qualifying events (e.g. new additions to the family, changes in eligibility, divorce, etc.) or changes in income.

**Terminations:** Exchanges will need to develop processes for communicating member information to public and private health plans for enrollees that decide to drop coverage (e.g., moving out of state, changing health plans based on qualifying events, switching to employer-sponsored health plan or public health plan) or members that do not pay their premium.

## 5. Clarify the Recommendation to Ensure User-Friendly Experience

To reduce the number of steps a consumer would need to take to enroll in a qualified health plan, consumers should have the option for eligibility and enrollment information they entered in the plan comparison tool to populate their enrollment form. Any information an exchange collects for purposes of making public program eligibility determinations should not need to be re-entered into an application for enrolling into a qualified health plan.

We recommend revising the following bullet under the heading, "Minimize Requirement to Submit Overwhelming Information":

**Eliminate duplicate requests for information:** Consumers should not have to re-enter information from one part of ~~the form to~~ the exchange eligibility process into an enrollment form, ~~another part of the form.~~ For instance, if a piece of information was asked for eligibility, it should not be asked again for enrollment.

\* \* \*

We appreciate your consideration of our comments. If you have any questions, please contact me at (202) 626-8639 or david.korsh@bcbsa.com.

Sincerely,

/s/

David Korsh  
Director, State Affairs

# Comments of the NAIC Consumer Representatives

June 7, 2011

The Honorable Theresa D. Miller  
Co-Chair, Consumer Information Working Group  
Insurance Administrator  
Oregon Insurance Division  
350 Winter Street, NE  
Salem, OR 97301-3883

Dear Administrator Miller: \_

We are writing to you as Consumer Representatives of the NAIC to comment on the proposed letter to the Secretaries of HHS and Labor regarding the development of streamlined and coordinated eligibility determination and enrollment processes as required in Section 1413 of the Patient Protection and Affordable Care Act, and Section 2715 of the Public Health Service Act.

We appreciate the efforts of the Consumer Information Subgroup charged with advising the agencies as they develop criteria for the certification of qualified health plans in the exchanges. On the whole, we find this initial set of considerations to be comprehensive, addressing many complex issues surrounding a streamlined eligibility and enrollment process for applicants of Medicaid, S-CHIP and premium credits and cost sharing subsidies. Further, we appreciate that more details about these and other procedures involving the operation of exchanges and qualified health plans have yet to be determined and shared with the public. We will be pleased to continue offering our expertise and experiences as consumer advocates as more is learned about the application process, collection and transfer of applicants' information in electronic and other formats, the risk adjustment process, methods to appropriately address applicants' language and cultural needs and more.

However, we do believe that the letter could be strengthened and clarified in a few areas, and offer the following suggestions.

## Clarify the Distinction Between Eligibility and Enrollment Functions

Although HHS is asking for criteria about an overall streamlined process -- one which is ideally seamless for the consumer--, it is still important to maintain the distinction between eligibility and enrollment so that the criteria submitted to HHS are clear. In fact, while the streamlined system that is being envisioned may look unified to consumers, the eligibility and enrollment "pathways" are likely to remain separate and distinct behind the scenes, and it is useful to conceptualize the new system this way. Further, consumers may review their health plan choices differently once they are made aware of the various programs they and/or members of their household are eligible for. To support the most informed decision possible, the systems should encourage an applicant to conduct the eligibility determination and enrollment process carefully and in step-wise fashion.



Eligibility is the term used to determine whether a person or a family meets the requirements for a particular program or type of assistance — in this case Medicaid, CHIP, or federally funded premium tax credits and cost-sharing reductions that are available to low- and moderate-income people getting coverage through an exchange. To determine eligibility for a program, it will be necessary to provide information about income and the members of a person's household. Enrollment refers to the process a person or family undergoes to sign up for a plan. To illustrate, a person who has reached the point of enrolling in an exchange plan with a premium credit would have already gone through an eligibility process.

To distinguish between eligibility and enrollment and clarify the recommendations to HHS, we suggest:

- Change references to “the combined eligibility and enrollment process” to eligibility and enrollment processes, which is used a number of times throughout the letter.
- In the paragraph on Page 3 that begins “Allow individuals to bypass enrollment questions for Medicaid, CHIP, tax credits...” the word “enrollment” should be changed to “eligibility.” In addition, this paragraph should distinguish more clearly between *determining eligibility* for a program or for subsidies and *screening for possible eligibility*. An “initial screening” would not provide the information necessary to make a determination of eligibility; screening is more basic than the eligibility process and is not sufficient to result in such a determination. Additionally, it makes sense to move the point before the prior bullet, as you would by-pass the eligibility before you'd bypass selected questions in the eligibility section. For similar reasons, we recommend moving point 5 before what is now point 2.
- On Page 6, in the section beginning “Address Cultural and Language Needs of Applicants,” there are several references to “eligibility workers.” We think this should be changed to reflect the fact that many different entities, organizations, and types of agency staff will be working to connect people with the appropriate coverage, not just people working on the eligibility process. For example, an exchange employee may or may not be considered an “eligibility worker.”

#### Consolidate Discussion of SHOP Exchange Considerations

Similarly, the discussion of considerations for eligibility and enrollment in an individual-market exchange should be kept separate from the discussion of issues related to SHOP exchanges. These are different sets of issues, and it would be helpful to organize the recommendations to make that clearer. For example, on Page 2, the paragraph beginning “Display Relevant Plan Choices when enrolling through the SHOP Exchange” could be moved to the final section of the letter that focuses on the enrollment system for the SHOP exchange. Also, if a single form is to be developed, it is not clear what the reference to “wrong form” on page 2 refers.

## Transparency vs. Streamlined Considerations

The discussion on page 2 acknowledges the importance of transparency generally. However, this discussion should be a lot clearer about the benefits of a streamlined form for consumers vs. complete transparency. Many states have found that hiding the underlying complexity of the eligibility determination process is very beneficial to enrolling consumers. In this case, complete transparency is not what is warranted.

## Additional Suggestions

- Throughout the document, references to “health subsidy programs” should be clarified at least the first time the term is used. The section on Page 2 titled “Design a Transparent and Consumer-Friendly User Experience” should include the suggestion that individuals assisting the applicant through the process online be able to log on as such to enter information for the applicant to complete the eligibility or enrollment questions. These helper portals should also allow the helper to see the disposition of eligibility and enrollment and flag when issues arise, such as the need for additional documentation to complete an eligibility determination. Even when eligibility and enrollment processes are completed with help from an assister, consumers should have access to their own accounts and be able to log in independently to make changes to their files.
- Another consumer aid would be to provide for verification to the applicant that he/she has completed the eligibility or enrollment process, or to highlight missing information that prevents its completion.
- On Page 3, the paragraph beginning “Design Appropriate Screenings for Dependents of Employees Enrolling into SHOP Exchanges,” incorrectly states that a person eligible to enroll in a SHOP exchange would not qualify for Medicaid or premium tax credits. It is important to make clear that a person could qualify for Medicaid even if their employer offers coverage through a SHOP exchange (or outside the exchange). However, we would not envision an eligibility determination as such for the SHOP exchange, where individuals will be working for a small business that is sending them to an exchange to obtain coverage. +
- On Page 4, in the bulleted section beginning “Applications for mixed-immigration status families...” it is incorrect to use the term “pro-rata adjustments.” The law provides for a formula, not a pro-rata adjustment that would be used in such cases.
- On Page 5, there is a discussion of the potential need for medical information to be collected for preventive care, wellness and chronic disease management programs as part of enrollment processes. In our view, this is unnecessary, invasive and could be harmful to consumers. Insurers should be able to query enrollees about their desire to participate in wellness and disease management programs only after they have enrolled in an insurer’s plan, not before. If a person says that they are interested in participating in such programs, then the insurer can request the needed information about medical conditions and health status. Adding this data is

counter to the goal of a streamlined form, raises concerns about consumer privacy, and overreaches as it appears on all forms, regardless of the interest in, or availability of, wellness programs. Furthermore, collecting this information could lead to “cherry picking” or “steering” tactics where people with serious illnesses or expensive health care needs could be put at a disadvantage or steered to particular products.

- On Page 6, we agree that application forms and other materials must be accessible to people who prefer to get information in languages other than English. We would note again that this should not be limited to “eligibility workers.” Many entities that serve consumers, including health plans and employers as well as government agencies and the exchange, must ensure that language is not a barrier for individuals and families and in many cases are already subject to requirements in this regard.
- On Page 6, we question what information could be appropriately gathered on an application to assess the cultural needs of consumers. We agree that it is important to ensure that applications and other materials provided to consumers present information in a culturally appropriate manner, but it is also important to avoid requesting unnecessary information about a person’s culture or background in a way that could be offensive. The goal of a streamlined form (with fewer questions) might outweigh the value of cultural needs questions. These could be asked after enrollment.

Thank you again for the opportunity to comment, and we look forward to continuing to work with you on your submission to HHS and Labor.

Sincerely,

Barbara Yondorf

Timothy Stoltzfus Jost

Joe Ditre

Bonnie Burns

Stephen Finan

Lynn Quincy

Sarah Lueck

Georgia Maheras

Kimberly Calder

June 7, 2011

National Association of Insurance Commissioners (NAIC)  
Consumer Information (B) Subgroup

Re: *Comments on the Draft Criteria for Uniform Enrollment Form (PPACA)*

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*National Advocates for  
Asian American,  
Native Hawaiian &  
Pacific Islander Health*

Dear NAIC,

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the National Association of Insurance Commissioners (NAIC), Consumer Information Subgroup for the opportunity to comment on the Draft Criteria for Uniform Enrollment Form under the Patient Protection and Affordable Care Act (PPACA).

APIAHF strongly supports NAIC's Draft Criteria and its emphasis on addressing linguistic and immigration-related barriers to enrollment in the Health Insurance Exchanges. In addition, we urge NAIC to consider the following modifications and additions to the Draft Criteria:

### **Design a Transparent and Consumer-Friendly User Experience**

- Include Telephone Assistance: In addition to providing assistance through visual tips and online chat, we recommend the addition of telephone assistance.

### **Minimize Requirements To Submit Overwhelming Information**

- Remove "Overwhelming": Remove "overwhelming" from this section heading and replace with "unnecessary" or "burdensome" information.
- Inform Non-applicant Caretakers of the Ability to Apply on Behalf of Another Individual: Notices, instructions and enrollment forms should inform non-applicant caretakers that they can apply on behalf of another individual, without submitting unnecessary personal data about themselves.

### **Ensure Efficient Handling of Complex Eligibility Situations**

- Rephrase the First Bullet Point under Recommendation 3 (Design Appropriate Screenings for Families with Mixed Eligibility and Immigration Status) to: "In order to meet the requirements, the application process should accommodate the fact that some lawfully present individuals may not have social security numbers, but may have other identifiers that can be used for verification."

### **Consider Other Important Consumer Concerns**

Data from the Census Bureau's American Community Survey reveal that over 19% of the United States population speaks a language other than English, and over 43% of them are considered "limited English proficient," meaning they speak English less than "very well" or not at all.<sup>1</sup> Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and

<sup>1</sup> Language Spoken at Home, U.S. Census Bureau, American Community Survey, 2005-2009 5-year Estimates. Available at [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-geo\\_id=01000US&-qr\\_name=ACS\\_2009\\_5YR\\_G00\\_S1601&-ds\\_name=ACS\\_2009\\_5YR\\_G00](http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2009_5YR_G00_S1601&-ds_name=ACS_2009_5YR_G00)

patient education programs. To that end, APIAHF recommends the addition of the following points to strengthen Recommendation 4 “Address Cultural and Language Needs of Applicants”:

- Collect Data on Spoken and Written Language Need: The collection of primary language data should include spoken and written language need to identify applicants who have language considerations that need to be taken into account.
- Ensure Compliance with Title VI and Section 1557 Non-Discrimination Requirements: APIAHF recommends bolstering the second bullet point with regard to translations by specifying that translations are required to ensure compliance with Title VI and Section 1557 non-discrimination provisions.
- Adopt the Current Centers for Medicare & Medicaid Services (CMS) Threshold for Translation: NAIC should recommend adoption of the current CMS and Office of Civil Rights LEP Guidance threshold for translation, rather than translation in the “most prominent languages.” Currently, CMS requires that all Medicare health plans translate marketing materials into the primary language spoken by at least “5% or 500 persons in a plan benefit package service area.”
- Translate Marketing Documents: To ensure limited English proficient individuals are able to fully participate in selecting their health insurance plans or programs, marketing materials should be translated into languages spoken by at least 5% or 500 persons in a plan benefit package service area.
- Provide Notice of the Right to Language Services: The uniform enrollment form should provide notice of a consumer/applicant’s right to language assistance through an interpreter, at no cost.

In conclusion, APIAHF appreciates the opportunity to comment on the Draft Criteria for Uniform Enrollment Form. Please contact Priscilla Huang, Associate Policy Director for the Asian & Pacific Islander American Health Forum at [phuang@apiahf.org](mailto:phuang@apiahf.org) with any questions or additional information.

Respectfully,



Kathy Lim Ko  
President & CEO  
Asian & Pacific Islander American Health Forum

**Comments from Health Care Services Corporation:**

Thank you for the opportunity to provide feedback on NAIC's Draft Criteria for the Uniform Enrollment Form. Below are Health Care Service Corporation's (HCSCs) comments:

**MINIMIZE REQUIREMENTS TO SUBMIT OVERWHELMING INFORMATION:**

With respect to Comment 4 in this Section, HHS may also consider that Exchanges could further eliminate duplicative information requests by saving enrollee profile information for use during subsequent open enrollment periods.

**COLLECT APPROPRIATE INFORMATION FOR HEALTH PLAN ENROLLMENT:**

With respect to Comment 1, we recommend that the transfer of information between public and private insurance programs be an electronic and real-time data transfer in order to facilitate enrollment and reduce wait times for enrollees.

Due to the same considerations, with respect to Comment 2, we recommend that non-electronic information be translated to an electronic data feed, as opposed to maintaining such information in paper or pdf format.

Please let us know if you have any questions.

Thank you

Jennifer Lombardo Dullum  
Senior Manager  
Legislative and Regulatory Implementation Office (LRIO)  
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June 7, 2011

Administrator Teresa Miller,  
Insurance Division, Oregon Department of Consumer & Business Services  
NAIC Consumer Information (B) Subgroup,  
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EVELYN F. IRELAND, CAE  
National Association  
of Dental Plans  
Dallas, TX

Dear Administrator Miller and the NAIC Consumer Working Group Members:

Thank you very much for the opportunity to forward our comments on the pending NAIC letter to HHS and the corresponding form regarding eligibility into the Exchanges. As statutory background to our comments, below are the corresponding PPACA references regarding dental.

PPACA Sec. 1311 (d)(2)(B)(ii) specifically states:

OFFERING OF STAND-ALONE DENTAL BENEFITS. – Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).  
[page 69 of the Consolidated Print]

Section 9832(c)(2)(A) of the Internal Revenue Code of 1986 defines benefits excepted from the definition of health plans under the code:

(c) Excepted benefits

For purposes of this chapter, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(2) Benefits not subject to requirements if offered separately:

(A) Limited scope dental or vision benefits.

PPACA Section 1302 (b)(1)(J) is the reference to dental as part of the Essential Health Benefits Package,  
(J) Pediatric services, including oral and vision care.

Thank you for your enormous efforts and dedication within this Subgroup. It is greatly appreciated from our industry, and again thank you for this opportunity to provide input. If you have any questions regarding our comments, please contact me directly at [khathaway@nadp.org](mailto:khathaway@nadp.org) or 972.458.9778 x111.

Sincerely, Kris Hathaway

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]



Draft Criteria for Uniform Enrollment Form: June 2, 2011 Draft

Exposed for Public Comment June 2, 2011 by the Consumer Information (B) Subgroup  
Send comments by email to [jsung@naic.org](mailto:jsung@naic.org) and [jcook@naic.org](mailto:jcook@naic.org) by Tues. June 7 at 12:00 noon Eastern.

Honorable Kathleen Sebelius  
Secretary  
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200 Constitution Avenue, NW  
Washington, DC 20210

Dear Secretary Sebelius and Secretary Solis:

We are pleased to provide you with items to consider as you develop criteria for a uniform enrollment form for individuals and employers enrolling into qualified health plans offered through health insurance Exchanges.

Section 1311 of the Affordable Care Act (PPACA) requires you to establish criteria for the certification of qualified health plans to include certification that the plan utilize a uniform enrollment form that takes into account criteria that the National Association of Insurance Commissioners (NAIC) develops and submits to the Secretary. PPACA also provides stand-alone dental plans shall be allowed to provide pediatric dental benefits through health insurance Exchanges. As result, our comments also address criteria for qualified dental plans.<sup>1</sup> We understand that your Departments intend to design a single streamlined eligibility and enrollment process to include the requirements of Section 1413. Section 1413 directs you to establish a streamlined procedure for applicants to receive eligibility determinations and enroll in state Medicaid, CHIP, and health subsidy programs, including individuals applying to an Exchange.

The suggested criteria below were developed by the NAIC's Consumer Information (B) Subgroup. This Subgroup was originally created to work with HHS and DOL to implement Section 1001 of PPACA (adding Section 2715 of the Public Health Service Act) and is comprised of NAIC members as well as a working group of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates and other qualified individuals.

We do not intend for this to be an exhaustive list of criteria to consider in the complicated task of implementing an eligibility and enrollment process. Rather, these are some initial issues to consider based on the experience of state regulators and other Subgroup members. These issues should be considered for both the electronic platform, as well as paper versions. As we all learn more about implementation of the eligibility and enrollment process, as well as about implementation of the health insurance Exchanges, we may have additional comments and criteria to suggest at a later time.

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<sup>1</sup> The American Health Benefit Exchange Model Act, the NAIC's model act designed to implement PPACA's exchange provisions at state level, refers to these stand-alone dental plans as "qualified dental plans", thus that term is used throughout our comments.



In addition, we understand that HHS has entered into a public-private partnership for the development and design of the online application and uniform enrollment form. The Consumer Information Subgroup would like to offer its experience and expertise as you move forward. We appreciate this opportunity to raise issues for you to consider in these early stages of development. However, because the Subgroup is made up of insurance regulators, representatives from the insurance industry, consumer representatives, health care professionals and other experts, we offer a unique perspective that can continue to be helpful. We look forward to having the opportunity to provide additional guidance in the future.

### **DESIGN A TRANSPARENT AND CONSUMER-FRIENDLY USER EXPERIENCE:**

While the combined eligibility and enrollment process will be simpler and more streamlined for the consumer than undergoing multiple separate applications, it may be a very confusing process for the average consumer. Not only does the eligibility and enrollment process need to be well-designed to ensure the proper collection of information, but it must also be designed with consumer needs in the forefront. The step-by-step process of moving from eligibility screenings to public program enrollment and/or to private plan enrollment must be transparent and understandable by the consumer. To this end, the Departments should consider the following:

1. **Recognize that Individuals Will Need Assistance Throughout Process:** During the process of education, plan comparison, eligibility, and enrollment, it is likely that many consumers will need assistance from neutral parties as well as friends and families. The Departments should consider the important role of such assistance, including the role of agents, brokers and navigators, throughout this process. In addition, the electronic enrollment format should be designed with such assistance in mind, and consider features such as links to definitions, visual tips to aid the consumer, online chat and other real-time supports.
2. **Clearly Differentiate Enrollment Through The Individual Market Versus the SHOP Exchange:** Near the beginning of the user experience, it should be clear to individuals whether they are enrolling through the individual market or whether they are enrolling through their employer's umbrella in the SHOP Exchange. Such clear designations will ensure that individuals do not end up completing the wrong form.
3. **Display Relevant Plan Choices when Enrolling through the SHOP Exchange:** PPACA permits employers to limit the number of plans available to their employees. Therefore, employees who are enrolling through their employer's umbrella in the SHOP Exchange should only be presented with the coverage offered by his/her employer, rather than presented with plans to which they may not be eligible.

### **MINIMIZE REQUIREMENTS TO SUBMIT OVERWHELMING INFORMATION:**

Since the uniform enrollment form will be combined with the eligibility process for Medicaid, CHIP, tax credits, and subsidies, the Departments should be mindful that requiring individuals to submit large quantities of information could become a barrier to participation and may

overwhelm the consumer. In addition to these screenings, state exchanges will also be required to meet other requirements of the law including verification of citizenship or lawful presence in United States and entitlement to an exemption of the individual responsibility requirement. Therefore, the Departments should consider the following suggestions:

1. **Work with States and Federal Agencies to keep the list of questions required for Medicaid, CHIP, tax credit, and subsidy eligibility to a minimum.** Keeping the number of these questions to a minimum, and pre-populating or pulling information from existing databases where appropriate (combined with an opportunity for enrollees to verify accuracy of such data), will make it simpler for all individuals to respond and quickly determine eligibility.
2. **Allow individuals to bypass enrollment questions for Medicaid, CHIP, tax credits, or subsidies if they are determined not to be eligible.** If the individual is eligible, then the process could continue and the individual could submit further information for enrollment into that plan. However, if individuals are determined not to be eligible in the initial screening, they should be permitted to proceed directly into enrollment into the Exchange.
3. **Consider giving individuals the choice to bypass eligibility for public programs, tax credits, or subsidies.** This would make the process simpler for individuals who are confident they are not eligible for public programs, subsidies, or tax credits. However, for online systems, there should be a threshold question to confirm ineligibility as well as a mechanism so that the individual can later change their mind and return to the eligibility screening without re-entering previously provided data if they later decide to be considered for public programs after first exploring Exchange options.
4. **Eliminate duplicate requests for information:** Consumers should not have to re-enter information from one part of the form to another part of the form. For instance, if a piece of information was asked for eligibility, it should not be asked again for enrollment.
5. **Consider giving individuals the ability to learn about their options for public and private coverage through a quick-screening process without having to enter personally identifiable data into the system.**

**ENSURE EFFICIENT HANDLING OF COMPLEX ELIGIBILITY SITUATIONS:**

The eligibility and enrollment process should be able to smoothly and efficiently handle families with mixed eligibility and immigration statuses. This might include situations where a family member may be eligible for the SHOP Exchange or to purchase individual coverage through the Exchange, while other members of the family are eligible for public programs or subsidies. This might also include situations where different members of the family have different immigration statuses. Another complicated mixed eligibility scenario may include situations where grandparents or non-biological parents are caring for children.

1. **Design Appropriate Screenings for Dependents of Employees Enrolling into SHOP Exchanges:** Generally, once an individual is determined to be eligible for enrollment into a SHOP Exchange, he/she will not qualify for Medicaid or premium tax credits, so they should not have to undergo such screening. However, in some cases dependents of the employee may qualify for Medicaid or other programs, so the eligibility system should be able to accommodate these types of situations without requiring the completion of unnecessary information or failing to give dependents an opportunity to determine eligibility.
2. **Assurance of Purpose and Confidentiality:** In order to prevent a deterrent effect, applications should explicitly identify the purpose of collecting information, such as immigration status, and clearly identify bounds of confidentiality and privacy. It should be noted that Section 1411(g) requires that only essential information be collected for the purposes of establishing eligibility.
3. **Design Appropriate Screenings for Families with Mixed Eligibility and Immigration Status:** It is anticipated that applications will need to account for income and lawful presence for all individuals. The eligibility and enrollment system should be sophisticated enough to make proper determinations for families with mixed eligibility and immigration status, and should consider the following:
  - In order to meet the requirements, the application process should accommodate the fact that not all lawfully present individuals have social security numbers.
  - The process should be able to accommodate families with mixed eligibility without requiring ineligible household members to complete unnecessary immigration status information.
  - The process should reflect differing eligibility rules for Medicaid and the Exchanges with regard to access for legal immigrants.
  - Applications for mixed-immigration status families should account for pro-rata adjustments in income and household size to ensure that the tax credits and cost-sharing determinations are calculated precisely for those who are eligible. This information should be relayed to the Internal Revenue Service (IRS) to ensure reconciliation during the assessment for tax penalties.
4. **Consistent Identifiers to Track Across Programs and Families:** A consistent identifier (SSN or other for those without) should be considered for individuals across programs (Medicaid, CHIP, subsidy-eligible, non-subsidy eligible). This would provide consistency and would allow States, Exchanges and health and dental plans to track individuals as they may shift between programs and eligibility categories. A consistent identifier to link families may also be useful to coordinate delivery and coordination of services among family members enrolled in different programs (e.g. SHOP, individual Exchange, Medicaid, CHIP). For example, such an identifier could be used to help assign family members to the same pediatrician, where appropriate.

**COLLECT APPROPRIATE INFORMATION FOR HEALTH PLAN AND QUALIFIED DENTAL ENROLLMENT:**

Implementation of the Exchanges and other new changes in law will bring changes in the way enrollment information is provided for health insurance carriers. The following issues should be considered:

1. **Collect Appropriate Information from Enrollees:** The information collected for enrollment into qualified health and qualified dental plans should be based on widely-used common standards so that health dental plans can ensure proper enrollment and transfer of information between public and private insurance programs. Since 2003, standard HIPAA transactions have been used to enroll consumers into public and private health coverage programs. Section 1561 of PPACA requires the development of standards to facilitate electronic enrollment, and more information on these recommendations can be found at <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161>
2. **Consider How Non-Electronic Information Will Be Transferred to Health Plans and Qualified Dental Plans:** Individuals will be able to continue to complete enrollment online, in person, by mail, or by telephone. As exchanges are being implemented, the Departments and States should consider the process by which health and dental plans will receive the submitted information from non-electronic submissions.
3. **Consider Changes to Collection of Medical Information:** As you know, as of 2014, medical questions will no longer be required for purposes of medical underwriting. These questions had previously made up of the bulk of the questions in uniform enrollment forms currently used by states. While we are not making any recommendations at this time, we wanted to flag two possible areas to be aware of relating to the collection of medical information.
  - Risk Adjustment: PPACA's risk adjustment provisions contemplate the use of medical information about plan participants which may require that certain limited medical questions be asked for this purpose. Although it is generally assumed that medical questions will not be needed during the enrollment process for this purpose, as more information is known about the risk adjustment process, this may be an area that we may revisit.
  - Preventive Care, Wellness and Chronic Disease Management Programs: Insurers currently use certain appropriate medical information collected in the enrollment process for these purposes. As more information about the enrollment process is made available, consideration may need to be given about the most appropriate point in the process (i.e. the plan comparison phase, enrollment, or in post-enrollment communications) to collect this type of information.

**CONSIDER OTHER IMPORTANT CONSUMER CONCERNS:**

The Departments should consider these additional consumer concerns:

1. **Address Privacy Concerns:** Individuals have raised privacy concerns that should be considered including:

- Concerns about being required to provide financial information if individuals believe they will not qualify for public programs, subsidies, or tax credits.
  - Concerns that private insurers should not have access to private financial information that may be provided earlier in the eligibility and enrollment process but is not necessary for enrollment into private insurance plans.
  - Concerns regarding the use of Social Security numbers.
  - In addition to standards for privacy and security of online enrollment and electronic data exchange, paper forms should also provide maximum privacy and security.
2. **Recognize Health Literacy Concerns:** While health literacy varies among the U.S. adult population, many Americans lack the skills needed to fully assess their health care options. Vulnerable populations (the elderly, minorities, immigrants, low-income individuals, and people with chronic mental and/or physical health conditions) are especially at risk, in part because many of these populations also have limited literacy skills. Many of the principles set forth elsewhere in this letter will assist those with lower health literacy skills. These include designing a transparent and consumer-friendly user experience and minimizing information requirements. However, segments of the population with low literacy skills still will need in-person and/or online assistance to correctly complete the enrollment forms. In addition, language should be written in a way that it is accessible to the largest number of people, the design should be created in a way to make the forms easy to read, and questions should be kept simple and provide definitions and examples.
3. **Recognize Digital Divide Concerns:** The process should recognize the fact that there are varying levels of access and comfort with technology. Individuals will continue to be able to complete enrollment forms in ways other than online, including in person, by mail, or by telephone. The Departments should also address varying community technological practices, including higher use of cell-phone technology in certain communities of color.
4. **Address Cultural and Language Needs of Applicants:** The application should gather information that helps eligibility workers identify the language and cultural needs of consumers. Resources should also be identified that provide easily-accessible assistance to applicants with language or cultural barriers.
- Section 4302 of PPACA requires the collection of primary language data to identify applicants who have language considerations that need to be taken into account.
  - Provide translations of uniform applications in the most prominent languages. Incorporate resource taglines for speakers of other languages and identify resources that provide assistance for individuals who speak other languages. Clearly outline obligations of eligibility workers to provide translation and interpretation services and other facilitated enrollment as part of the application process.
  - Address higher unfamiliarity with health systems by testing and provide translations of key health terminology to ensure standardized use of health terminology. (e.g. translations of the Exchange needs to relay what it is and create common understanding of the term).

## **DESIGN APPROPRIATE SYSTEM FOR EMPLOYER ENROLLMENT INTO SHOP EXCHANGES:**

The enrollment of small employers into the SHOP exchange poses a unique set of design challenges. In order to establish a smooth enrollment process and minimize confusion, the Departments should consider the following:

1. **Ensure a Clear Process for Employer Applicants for the SHOP Exchange:** Just as there should be a clear process for employees enrolling through the SHOP exchange so that individuals do not enroll through the wrong process, there should also be a clear and distinct process for employers enrolling in the SHOP Exchange.
2. **Collect Appropriate Information Required to Enroll Employers:** The enrollment of employers into the SHOP Exchange will require additional information to be collected. This should include:
  - a. Question identifying the broker, agent, navigator, business owner or other employee at the company responsible for enrollment.
  - b. Method for the employer to upload their wage and tax report to verify that the individuals being enrolled through the employer group are actually employees.
  - c. Question about whether the employer has had previous coverage, the effective dates of that coverage, and the most recent billing statement. Confidentiality of the wage information would also need to be addressed.
  - d. Other data elements that are currently being collected for the small group market such as location, employer identification number, etc.
3. **Properly Display Choice of Plan Selections:** PPACA permits employers to authorize one or more employee selections within a level of coverage (bronze, silver, etc), so there needs to be a listing of what those plan selections are, and the employer has to be given an opportunity to make that selection. Not all plans may be available to every employee. Once the employer chooses the plan or plans they wish to make available to their employees, if presented with a choice among plans, employees who subsequently enroll should be presented only with those plan choices.

Draft Criteria for HHS on Uniform Enrollment Form:  
May 27, 2011 Draft

**Background:**

1. Describe the NAIC's role and our charge in statute
2. State concerns
3. This is not an exhaustive list of things to consider. There are many issues to consider, so these are limited to issues that are based on the experience of state regulators and members of the Consumer Info Subgroup. We also want to provide this information in a timely matter since we are aware that HHS is under tight implementation timelines. We may have additional suggestions for criteria and recommendations as we learn more about HHS' implementation of the enrollment form.
4. The following are criteria that we suggest that HHS consider as you implement the uniform enrollment and eligibility form.

**Considerations For Enrollment of Individuals [including employees enrolling into the SHOP Exchange]**

1. **Clear Navigation / Consumer Friendly User Experience:** The following criteria should be considered to help ensure a consumer-friendly experience for consumers undergoing the eligibility and enrollment process.
  - A. **Clearly Designate Enrollment Through The Individual Market Versus the SHOP Exchange:** Near the beginning of the user experience, it should be clear to individuals whether they are enrolling through the individual market or whether they are enrolling through their employer's umbrella in the SHOP Exchange. Such clear designations will ensure that individuals do not end up completing the wrong form.
  - B. **Display Relevant Plan Choices when Enrolling through the SHOP Exchange:** PPACA permits employers to limit the number of plans available to their employees. Therefore, employees who are enrolling through their employer's umbrella in the SHOP Exchange should clearly be presented with the choices offered by his/her employer, and not every plan to which they may not be eligible.
  - C. **Minimize Requirements to Submit Overwhelming Information:** Since HHS is combining the uniform enrollment form with the eligibility process for Medicaid, CHIP, tax credits, and subsidies, there is potential that individuals will be required to submit so much information that could become a potential barrier to participation. In addition to these screenings, state exchanges will also be required to meet other requirements of the law including verification of citizenship or lawful presence in United States and entitlement to an exemption of the individual responsibility requirement. Therefore, HHS should consider the following suggestions:

- 1) **Work with States and Federal Agencies to keep the list of questions required for Medicaid, CHIP, tax credit, and subsidy eligibility to a minimum.** Keeping the number of these questions to a minimum will make it simpler for all individuals to respond and quickly determine eligibility.
- 2) **Allow individuals to bypass enrollment questions for Medicaid, CHIP, tax credits, or subsidies if they determined not to be eligible.** If the individual is eligible, then the process could continue and the individual could submit further information for enrollment into that plan. However, if individuals are determined not to be eligible in the initial screening, they should be permitted to proceed directly into enrollment into the Exchange.
- 3) **Consider giving individuals the choice to bypass eligibility for public programs, tax credits, or subsidies.** This would make the process simpler for individuals who are confident they are not eligible for public programs, subsidies, or tax credits. However, there should also be a mechanism so that the individual can later change their mind and return to the eligibility screening if they later decide to fill out that section.
- 4) **Eliminate duplicate requests for information:** Consumers should not have to re-enter information from one part of the form to another part of the form. For instance, if a piece of information was asked for eligibility, it should not be asked again for enrollment.

5) Consider how ancillary products may be included inside and outside AHBE and SHOP. Section 1311(d)(2) allows separate dental policies to provide at a minimum the pediatric oral service of the required essential benefits inside both Exchanges. An enrollment question may need to include number of dependents and age to make sure the required pediatric oral health coverage is included in an enrollee's purchasing choice. In addition, an enrollment question is needed for parents who already have dental coverage that meets the essential health benefit package for their children.

Comment [KH1]: Could be moved to placeholder #6

- D. **Electronic Interface Should Help Inform the Consumer:** The electronic enrollment format should provide links to definitions and tips to aid the consumer throughout the process. [Added this after the Utah demo]
- E. **User-Friendly Handling of Mixed Eligibility and Immigration Status for Families:** [Needs to be expanded]
  - 1) Design suggestions for handling this.
  - 2) What questions will need to be asked to properly make these determinations.
  - 3) Any other suggestions.
- F. **Appropriate Eligibility and Enrollment Screenings for SHOP Exchange:**



- 1) Generally, individuals who qualify to enroll as an employee through the SHOP Exchange will not qualify for Medicaid or premium tax credits, so they should not have to undergo such screening.
- 2) However, in some cases the dependents may qualify, so the eligibility system should be able to accommodate these types of situations without requiring the completion of unnecessary information or failing to give dependents an opportunity to determine eligibility.

**2. Information to be Collected for Health Plan Enrollment:**

- A. **Accommodate Different Methods of Enrollment:** Individuals will be able to complete enrollment online, in person, by mail, or by telephone. The eligibility and enrollment process should provide individuals to use any of these methods. [Do we need to say this, or delete?]
- B. **Transfer of Enrollment Information Into Electronic Format:** Health plans should receive the submitted information needed for enrollment into a qualified health plan electronically from an Exchange. This would include the conversion of any paper application to an electronic format, then transmitted to a health plan. [Who would be responsible for this? Does everyone agree with this?]
- C. **Appropriate Collection of Information from Enrollees:** The information collected for enrollment into qualified health plans should be based on widely used common standards so that health plans can ensure proper enrollment and transfer of information between public and private insurance programs. Since 2003, standard HIPAA transactions have been used to enroll consumers into public and private health coverage programs. Section 1561 of PPACA requires the development of standards to facilitate electronic enrollment, and more information on these recommendations can be found at <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161>
- D. **Consider Changes to Collection of Medical Information:** As you know, as of 2014 medical underwriting questions will no longer be required. These questions had previously made up of the bulk of questions for uniform enrollment forms currently used by states. While we are not making any recommendations at this time, we wanted to flag two possible areas to be aware of relating to the collection of medical information. It is not clear whether any questions should be collected in conjunction with the enrollment process at this time.
  - 1) Risk Adjustment: PPACA's risk adjustment provisions may require that certain limited medical questions be sought for this purpose. Although it is generally assumed that medical questions will not be needed during the enrollment process for this purpose, as more information is known about the risk adjustment process, this may be an area that the Subgroup may revisit.
  - 2) Preventive Care, Wellness and Chronic Disease Management Programs: Insurers currently use certain appropriate medical information collected in the enrollment process for these purposes. As more information about the

**Comment [KH2]:** Dental can use the same enrollment information as medical. Claim forms are the only HIPAA transaction in which dental is different than medical.

enrollment process is made available, consideration may need to be given about the most appropriate point in the process (i.e. the plan comparison phase, enrollment, or in post-enrollment communications) to collect this type of information.

3. **Privacy Concerns:** [Needs further discussion]

A. Issues that have been raised:

- 1) Individuals should have the option not to enter financial information if they believe they will not qualify for public programs, subsidies, or tax credits.
- 2) Private financial information not necessary for enrollment into private insurance should not be accessible by private insurers.
- 3) Concerns with use of social security numbers.

4. **Health Literacy Concerns** [Needs discussion]

[Question from HHS: How to address varying levels of experience with health insurance and health literacy?]

5. **Cultural and Language aspects** [Needs discussion]

[Question from HHS: How to handle diverse cultural and linguistic access needs?]

[Also, question was raised about translation considerations for both consumers and insurers].

6. **Dental and Vision Plans** [Needs discussion]

**Considerations relating to small employer enrollment into the SHOP Exchange:**

1. **Clear Process for Employer Applicants:** Just as there should be a clear process for employees enrolling through the SHOP exchange so that individuals do not enroll through the wrong process, there should also be a clear and distinct process for employers enrolling in the SHOP Exchange.
2. **Information Required to Enroll Employers:** The enrollment of employers into the SHOP Exchange will require additional information to be collected. This should include:
  - a. Question identifying the broker
  - b. Question about whether the employees enrolling in the coverage are 30 hours a week or more.
  - c. Method for the employer to upload their wage and tax report to verify that the individuals being enrolled through the employer group are actually employees.
  - d. Question about whether the employer has had previous coverage, the effective dates of that coverage, and the most recent billing statement.
  - e. Other data elements that are currently being collected for the small group market such as location, employer identification number, etc.

3. **Choice of Plan Selections:** PPACA permits employers to authorize one or more employee selections from each category (bronze, silver, etc), so there needs to be a listing of what those plan selections are, and the employer has to be given an opportunity to make that selection. Not all plans may be available to every employee. Once the employer chooses the plans they wish to make available to their employees, employees who subsequently enroll should be presented only with those plan choices.



**L. Chris Petersen**  
202-408-5147  
cpetersen@mmmlaw.com  
www.mmmlaw.com

June 7, 2011

Administrator Teresa Miller  
Oregon Insurance Division  
P.O. Box 14480  
Salem, OR 97309-0405

Re: Enrollment Form

Dear Administrator Miller:

I am writing on behalf of the Delta Dental Plans Association (“Delta Dental”) to provide comments on the June 2, 2011 Draft Criteria for Uniform Enrollment Form. Delta Dental is the nation’s largest, most experienced dental benefits company. Since 1954, Delta Dental has worked to improve oral health in the U.S. by emphasizing preventive care and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers, groups, and individuals. Delta Dental plans, as with most dental benefit plans, are offered as “stand alone” independent benefits, contracted and administered separately from medical benefits. The Delta Dental nationwide network serves more than 54 million Americans in over 89,000 group plans across the nation.

Delta Dental understands that the major focus of the enrollment form criteria will be comprehensive major medical coverage; however, since stand-alone dental coverage will also be offered through exchanges we feel it is important the criteria also address dental coverage and dental issues. We have included a redlined version of the June 2, 2011 draft which incorporates changes that make it clear that dental coverage may be offered through the exchange and which hopefully also makes it clear that, where appropriate, the enrollment criteria should also apply to dental plans that participate in the exchanges, i.e., “qualified dental plans.”

On the Subgroup’s conference call last Thursday I raised two issues that the Subgroup might want to consider highlighting to Secretary Sebelius. The first issue was related to the privacy discussion in the June 2, 2011 draft. Delta Dental believes that the HIPAA privacy concept of “minimum necessary” should apply to the information collected on, and transmitted from, the



June 8, 2011

Page 2

enrollment form. The information collected on the enrollment form should only include the information that is necessary to determine the types of coverages/program that individuals are eligible for and the information transmitted to insurers and state programs should only be the minimum necessary to enroll individuals into the appropriate coverage. For example, major medical writers will probably need more health information from applicants than will be needed by dental insurers. Whatever system is utilized to transmit the information collected from the enrollment form should be designed to distinguish between different insurers and state program and transmit only that health information that is needed by the insurer or state program.

I also raised the issue as to whether the enrollment form will collect what I referred to as "consumer-driven preferences." By this I mean, will the enrollment form collect information from consumers regarding factors that the consumer believes is important in selecting an insurer. Under this concept the exchange, using information on the enrollment form, could help direct individuals to the major medical and dental coverage that meets the consumers stated preferences.

Examples of the type of preferences that might be collected could include whether the individual would prefer HMO versus PPO coverage. Some consumers might want to limit their review of coverage to those plans that include their preferred doctor, dentist or hospital. The enrollment form could collect information regarding preferred medical/dental providers and then direct the individual only to those plans that include these providers and/or facilities. The enrollment form could also ask if the individual has a preferred medical or dental insurer or the converse, is there an insurer that they did not wish to use. I am sure there are several other types of questions that could be developed to help consumer pick the coverage that best meets their needs. Absent consumer-driven preference questions on the enrollment form, consumers will need to wade their way through the myriad plans participating on the exchange in hopes of finding the plan that best meets their needs.

Thank you for your consideration. I will be available on your upcoming conference calls if you would like to discuss these issues in more detail.

Sincerely,

L. Chris Petersen

Cc: Jane Sung  
Elizabeth Schumacher

Draft Criteria for Uniform Enrollment Form: June 2, 2011 Draft

Exposed for Public Comment June 2, 2011 by the Consumer Information (B) Subgroup  
Send comments by email to [jsung@naic.org](mailto:jsung@naic.org) and [jcook@naic.org](mailto:jcook@naic.org) by Tues. June 7 at 12:00 noon Eastern.

Honorable Kathleen Sebelius  
Secretary  
US Department of Health and Human Services (HHS)  
200 Independence Avenue, SW  
Washington, DC 20201

Honorable Hilda Solis  
Secretary  
US Department of Labor (DOL)  
200 Constitution Avenue, NW  
Washington, DC 20210

Dear Secretary Sebelius and Secretary Solis:

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The suggested criteria below were developed by the NAIC's Consumer Information (B) Subgroup. This Subgroup was originally created to work with HHS and DOL to implement Section 1001 of PPACA (adding Section 2715 of the Public Health Service Act) and is comprised of NAIC members as well as a working group of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates and other qualified individuals.

We do not intend for this to be an exhaustive list of criteria to consider in the complicated task of implementing an eligibility and enrollment process. Rather, these are some initial issues to consider based on the experience of state regulators and other Subgroup members. These issues should be considered for both the electronic platform, as well as paper versions. As we all learn more about implementation of the eligibility and enrollment process, as well as about implementation of the health insurance Exchanges, we may have additional comments and criteria to suggest at a later time.

In addition, we understand that HHS has entered into a public-private partnership for the development and design of the online application and uniform enrollment form. The Consumer Information Subgroup would like to offer its experience and expertise as you move forward. We appreciate this opportunity to raise issues for you to consider in these early stages of development. However, because the Subgroup is made up of insurance regulators, representatives from the insurance

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industry, consumer representatives, health care professionals and other experts, we offer a unique perspective that can continue to be helpful. We look forward to having the opportunity to provide additional guidance in the future.

### **DESIGN A TRANSPARENT AND CONSUMER-FRIENDLY USER EXPERIENCE:**

While the combined eligibility and enrollment process will be simpler and more streamlined for the consumer than undergoing multiple separate applications, it may be a very confusing process for the average consumer. Not only does the eligibility and enrollment process need to be well-designed to ensure the proper collection of information, but it must also be designed with consumer needs in the forefront. The step-by-step process of moving from eligibility screenings to public program enrollment and/or to private plan enrollment must be transparent and understandable by the consumer. To this end, the Departments should consider the following:

1. **Recognize that Individuals Will Need Assistance Throughout Process:** During the process of education, plan comparison, eligibility, and enrollment, it is likely that many consumers will need assistance from neutral parties as well as friends and families. The Departments should consider the important role of such assistance, including the role of agents, brokers and navigators, throughout this process. In addition, the electronic enrollment format should be designed with such assistance in mind, and consider features such as links to definitions, visual tips to aid the consumer, online chat and other real-time supports.
2. **Clearly Differentiate Enrollment Through The Individual Market Versus the SHOP Exchange:** Near the beginning of the user experience, it should be clear to individuals whether they are enrolling through the individual market or whether they are enrolling through their employer's umbrella in the SHOP Exchange. Such clear designations will ensure that individuals do not end up completing the wrong form.
3. **Display Relevant Plan Choices when Enrolling through the SHOP Exchange:** PPACA permits employers to limit the number of plans available to their employees. Therefore, employees who are enrolling through their employer's umbrella in the SHOP Exchange should only be presented with the coverage offered by his/her employer, rather than presented with plans to which they may not be eligible.

### **MINIMIZE REQUIREMENTS TO SUBMIT OVERWHELMING INFORMATION:**

Since the uniform enrollment form will be combined with the eligibility process for Medicaid, CHIP, tax credits, and subsidies, the Departments should be mindful that requiring individuals to submit large quantities of information could become a barrier to participation and may overwhelm the consumer. In addition to these screenings, state exchanges will also be required to meet other requirements of the law including verification of citizenship or lawful presence in United States and entitlement to an exemption of the individual responsibility requirement. Therefore, the Departments should consider the following suggestions:

1. **Work with States and Federal Agencies to keep the list of questions required for Medicaid, CHIP, tax credit, and subsidy eligibility to a minimum.** Keeping the number of these questions to a minimum, and pre-populating or pulling information from existing databases where appropriate (combined with an opportunity for enrollees to



verify accuracy of such data), will make it simpler for all individuals to respond and quickly determine eligibility.

2. **Allow individuals to bypass enrollment questions for Medicaid, CHIP, tax credits, or subsidies if they are determined not to be eligible.** If the individual is eligible, then the process could continue and the individual could submit further information for enrollment into that plan. However, if individuals are determined not to be eligible in the initial screening, they should be permitted to proceed directly into enrollment into the Exchange.
3. **Consider giving individuals the choice to bypass eligibility for public programs, tax credits, or subsidies.** This would make the process simpler for individuals who are confident they are not eligible for public programs, subsidies, or tax credits. However, for online systems, there should be a threshold question to confirm ineligibility as well as a mechanism so that the individual can later change their mind and return to the eligibility screening without re-entering previously provided data if they later decide to be considered for public programs after first exploring Exchange options.
4. **Eliminate duplicate requests for information:** Consumers should not have to re-enter information from one part of the form to another part of the form. For instance, if a piece of information was asked for eligibility, it should not be asked again for enrollment.
5. **Consider giving individuals the ability to learn about their options for public and private coverage through a quick-screening process without having to enter personally identifiable data into the system.**

#### **ENSURE EFFICIENT HANDLING OF COMPLEX ELIGIBILITY SITUATIONS:**

The eligibility and enrollment process should be able to smoothly and efficiently handle families with mixed eligibility and immigration statuses. This might include situations where a family member may be eligible for the SHOP Exchange or to purchase individual coverage through the Exchange, while other members of the family are eligible for public programs or subsidies. This might also include situations where different members of the family have different immigration statuses. Another complicated mixed eligibility scenario may include situations where grandparents or non-biological parents are caring for children.

1. **Design Appropriate Screenings for Dependents of Employees Enrolling into SHOP Exchanges:** Generally, once an individual is determined to be eligible for enrollment into a SHOP Exchange, he/she will not qualify for Medicaid or premium tax credits, so they should not have to undergo such screening. However, in some cases dependents of the employee may qualify for Medicaid or other programs, so the eligibility system should be able to accommodate these types of situations without requiring the completion of unnecessary information or failing to give dependents an opportunity to determine eligibility.

2. **Assurance of Purpose and Confidentiality:** In order to prevent a deterrent effect, applications should explicitly identify the purpose of collecting information, such as immigration status, and clearly identify bounds of confidentiality and privacy. It should be noted that Section 1411(g) requires that only essential information be collected for the purposes of establishing eligibility.
3. **Design Appropriate Screenings for Families with Mixed Eligibility and Immigration Status:** It is anticipated that applications will need to account for income and lawful presence for all individuals. The eligibility and enrollment system should be sophisticated enough to make proper determinations for families with mixed eligibility and immigration status, and should consider the following:
  - In order to meet the requirements, the application process should accommodate the fact that not all lawfully present individuals have social security numbers.
  - The process should be able to accommodate families with mixed eligibility without requiring ineligible household members to complete unnecessary immigration status information.
  - The process should reflect differing eligibility rules for Medicaid and the Exchanges with regard to access for legal immigrants.
  - Applications for mixed-immigration status families should account for pro-rata adjustments in income and household size to ensure that the tax credits and cost-sharing determinations are calculated precisely for those who are eligible. This information should be relayed to the Internal Revenue Service (IRS) to ensure reconciliation during the assessment for tax penalties.
4. **Consistent Identifiers to Track Across Programs and Families:** A consistent identifier (SSN or other for those without) should be considered for individuals across programs (Medicaid, CHIP, subsidy-eligible, non-subsidy eligible). This would provide consistency and would allow States, Exchanges and health [and dental](#) plans to track individuals as they may shift between programs and eligibility categories. A consistent identifier to link families may also be useful to coordinate delivery and coordination of services among family members enrolled in different programs (e.g. SHOP, individual Exchange, Medicaid, CHIP). For example, such an identifier could be used to help assign family members to the same pediatrician, where appropriate.

#### **COLLECT APPROPRIATE INFORMATION FOR HEALTH PLAN [AND QUALIFIED DENTAL ENROLLMENT:](#)**

Implementation of the Exchanges and other new changes in law will bring changes in the way enrollment information is provided for health insurance carriers. The following issues should be considered:

1. **Collect Appropriate Information from Enrollees:** The information collected for enrollment into qualified health [and qualified dental](#) plans should be based on widely-used common standards so that health [dental](#) plans can ensure proper enrollment and transfer of information between public and private insurance programs. Since 2003, standard HIPAA transactions have been used to enroll consumers into public and private

health coverage programs. Section 1561 of PPACA requires the development of standards to facilitate electronic enrollment, and more information on these recommendations can be found at

<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161>

2. **Consider How Non-Electronic Information Will Be Transferred to Health Plans and Qualified Dental Plans:** Individuals will be able to continue to complete enrollment online, in person, by mail, or by telephone. As exchanges are being implemented, the Departments and States should consider the process by which health and dental plans will receive the submitted information from non-electronic submissions.
3. **Consider Changes to Collection of Medical Information:** As you know, as of 2014, medical questions will no longer be required for purposes of medical underwriting. These questions had previously made up of the bulk of the questions in uniform enrollment forms currently used by states. While we are not making any recommendations at this time, we wanted to flag two possible areas to be aware of relating to the collection of medical information.
  - Risk Adjustment: PPACA’s risk adjustment provisions contemplate the use of medical information about plan participants which may require that certain limited medical questions be asked for this purpose. Although it is generally assumed that medical questions will not be needed during the enrollment process for this purpose, as more information is known about the risk adjustment process, this may be an area that we may revisit.
  - Preventive Care, Wellness and Chronic Disease Management Programs: Insurers currently use certain appropriate medical information collected in the enrollment process for these purposes. As more information about the enrollment process is made available, consideration may need to be given about the most appropriate point in the process (i.e. the plan comparison phase, enrollment, or in post-enrollment communications) to collect this type of information.

**CONSIDER OTHER IMPORTANT CONSUMER CONCERNS:**

The Departments should consider these additional consumer concerns:

1. **Address Privacy Concerns:** Individuals have raised privacy concerns that should be considered including:
  - Concerns about being required to provide financial information if individuals believe they will not qualify for public programs, subsidies, or tax credits.
  - Concerns that private insurers should not have access to private financial information that may be provided earlier in the eligibility and enrollment process but is not necessary for enrollment into private insurance plans.
  - Concerns regarding the use of Social Security numbers.
  - In addition to standards for privacy and security of online enrollment and electronic data exchange, paper forms should also provide maximum privacy and security.

2. **Recognize Health Literacy Concerns:** While health literacy varies among the U.S. adult population, many Americans lack the skills needed to fully assess their health care options. Vulnerable populations (the elderly, minorities, immigrants, low-income individuals, and people with chronic mental and/or physical health conditions) are especially at risk, in part because many of these populations also have limited literacy skills. Many of the principles set forth elsewhere in this letter will assist those with lower health literacy skills. These include designing a transparent and consumer-friendly user experience and minimizing information requirements. However, segments of the population with low literacy skills still will need in-person and/or online assistance to correctly complete the enrollment forms. In addition, language should be written in a way that it is accessible to the largest number of people, the design should be created in a way to make the forms easy to read, and questions should be kept simple and provide definitions and examples.
3. **Recognize Digital Divide Concerns:** The process should recognize the fact that there are varying levels of access and comfort with technology. Individuals will continue to be able to complete enrollment forms in ways other than online, including in person, by mail, or by telephone. The Departments should also address varying community technological practices, including higher use of cell-phone technology in certain communities of color.
4. **Address Cultural and Language Needs of Applicants:** The application should gather information that helps eligibility workers identify the language and cultural needs of consumers. Resources should also be identified that provide easily-accessible assistance to applicants with language or cultural barriers.
  - Section 4302 of PPACA requires the collection of primary language data to identify applicants who have language considerations that need to be taken into account.
  - Provide translations of uniform applications in the most prominent languages. Incorporate resource taglines for speakers of other languages and identify resources that provide assistance for individuals who speak other languages. Clearly outline obligations of eligibility workers to provide translation and interpretation services and other facilitated enrollment as part of the application process.
  - Address higher unfamiliarity with health systems by testing and provide translations of key health terminology to ensure standardized use of health terminology. (e.g. translations of the Exchange needs to relay what it is and create common understanding of the term).

#### **DESIGN APPROPRIATE SYSTEM FOR EMPLOYER ENROLLMENT INTO SHOP EXCHANGES:**

The enrollment of small employers into the SHOP exchange poses a unique set of design challenges. In order to establish a smooth enrollment process and minimize confusion, the Departments should consider the following:

1. **Ensure a Clear Process for Employer Applicants for the SHOP Exchange:** Just as there should be a clear process for employees enrolling through the SHOP exchange so

that individuals do not enroll through the wrong process, there should also be a clear and distinct process for employers enrolling in the SHOP Exchange.

2. **Collect Appropriate Information Required to Enroll Employers:** The enrollment of employers into the SHOP Exchange will require additional information to be collected. This should include:
  - a. Question identifying the broker, agent, navigator, business owner or other employee at the company responsible for enrollment.
  - b. Method for the employer to upload their wage and tax report to verify that the individuals being enrolled through the employer group are actually employees.
  - c. Question about whether the employer has had previous coverage, the effective dates of that coverage, and the most recent billing statement. Confidentiality of the wage information would also need to be addressed.
  - d. Other data elements that are currently being collected for the small group market such as location, employer identification number, etc.
  
3. **Properly Display Choice of Plan Selections:** PPACA permits employers to authorize one or more employee selections within a level of [health and/or dental](#) coverage (bronze, silver, etc), so there needs to be a listing of what those plan selections are, and the employer has to be given an opportunity to make that selection. Not all plans may be available to every employee. Once the employer chooses the plan or plans they wish to make available to their employees, if presented with a choice among plans, employees who subsequently enroll should be presented only with those plan choices.