



June 7, 2011

Administrator Teresa Miller,
Insurance Division, Oregon Department of Consumer & Business Services
NAIC Consumer Information (B) Subgroup,
National Association of Insurance Commissioners

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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 or 972.458.9778 x111.

Sincerely, Kris Hathaway

National Association of Dental Plans

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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 and 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:

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.¹ 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.

¹ 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.