June 19, 2015

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Attn: Document Identifier/OMB Control Number CMS–10488
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-10488—Health Insurance Marketplace Consumer Experience Surveys: Qualified Health Plan Enrollee Experience Survey

- With comments from Blue Cross Blue Shield of Michigan noted in yellow

Submitted via email: http://www.regulations.gov

Dear Sir or Madam:

America's Health Insurance Plans (AHIP) is writing in response to the Centers for Medicare and Medicaid Services' (CMS) Comment Request for Enrollee Satisfaction Survey Data Collection published in the *Federal Register* on April 28, 2015 (80 FR 23556). We look forward to working with CMS to implement section 1311(c)(4) of the Affordable Care Act (ACA) requiring the development of an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through the Exchange (Marketplaces).

AHIP is the national 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 supports the insurance Marketplaces as one option among many to provide consumers with access to health plan choices and clear and consistent information that can help aid decisions about coverage options.

Our member plans have extensive experience with both the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey and the Medicare Advantage and the Prescription Drug Plan Surveys. These surveys are well-established methods of capturing consumer assessments of health plan performance. CAHPS® is required by the National Committee on Quality Assurance (NCQA) and URAC for health plan accreditation, and is also used by many public and private purchasers. In light of their extensive experience with the CAHPS® surveys, our member plans have devoted significant time and effort in reviewing the survey instruments that will assess consumer experience with the Marketplaces and the QHPs and are actively involved in the ongoing beta test.

The draft 2016 QHP Enrollee Satisfaction survey posted on the CMS website contains modifications from last year's version primarily the re-introduction of questions related to patient

experience with their health plan as well as health literacy; therefore, we would like to reiterate comments from our previous letters to CMS regarding the QHP survey, and share additional feedback reflecting early results from the beta test. It is critical that the survey instrument be designed such that responsibility is allocated to the entity (e.g. Marketplace, QHP issuer, etc.) that has control over what is being assessed. Overall we recommend:

- Take steps to ensure an increased response rate such as reducing the total number of questions in the survey and develop a mobile/internet format for the survey.

- Ensure reliable cognitive testing of questions especially those that are new to CAHPS;

- Publicly share results of the cognitive testing for all newly added questions to the QHP survey in future public comment periods;

- Ensure accuracy of the survey results through validity and reliability testing of the survey tool and results prior to implementation;

- Account for any satisfaction differences across metal levels; and

We also offer the following set of comments specific to questions on the QHP Enrollee Satisfaction Survey.

I. Comments on the Qualified Health Plan Survey Questions

The QHP survey as drafted assesses the enrollee's experience with the health care system, such as communication skills of providers and ease of access of health care services. While we appreciate that CMS based the QHP survey on the existing CAHPS Health Plan Survey as well as developed new non-CAHPS questions for the QHP survey, we have several overarching concerns with this survey.

We would like to reiterate that we remain concerned with the length of the survey as it contains 85 questions up from 76 in last year's survey. As a comparison, it is challenging to obtain question level completeness of the adult Medicaid CAHPS, which has 39 questions. CMS should use the beta test response rates to inform a decision to reduce the length of the current survey – especially in the "About You" section. Also, while the QHP scoring methodology will consider case mix adjustments and weighting procedures, it needs to take into account substantively meaningful differences in quality across plans. If plans' scores on a given question are proven to be very tightly clustered around comparative benchmarks used in the data provided to the issuers, then CMS should reconsider whether a measure adequately provides consumers with meaningful information and continued inclusion in the survey should be assessed. Issuers have reported early results from the 2015 beta test that indicated a much lower than expected response rate. This supports the need to significantly reduce the number of questions (especially the "About You" questions) and reconsider the need for the new questions regarding affordability.

a. Existing CAHPS Health Plan Questions

QHP Survey questions 14-31 ask about an enrollee's personal doctor and focus on provider communication and care coordination. To be truly reflective of a QHP's performance, we support the replacement of these measures with the inclusion of questions that capture information about the quality of the plan's provider network and that are applicable to areas that health plans can directly influence. A health plan's ability to influence clinicians can vary by type of provider and network. For example, the ACA requires that health plans include specific providers in their network who may not have previously contracted with private health insurers and been part of performance reporting and consumer reviews (e.g., essential community providers). Additionally, such providers may not initially have the capacity to undertake quality improvement efforts needed to promote quality and patient satisfaction.

Under the "Your Personal Doctor" questions, questions 20 and 25 are speculative and are constructed in a way which will rely on the patient to communicate that the action occurred. If the intent of these questions is to assess the implementation and use of electronic medical records, we recommend revising the questions to better reflect the use of health information technology.

- [BCBS Michigan] If Questions 20 and 25 are kept, a "don't know" response option should be included:
    - "When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?"
    - "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?"

Additionally, while we are supportive of questions that assess the health plan, we have several recommendations for the "Your Health Plan" section:

- Questions 36 and 37 ask about written materials or Internet information about health plans. It is unclear whether CMS' intent is to measure plans' performance in providing information about the plan to consumers. Because these questions do not specify written materials *from your health plan* or *your health plan's website*, respondents are likely to reference other sources of written materials or websites. For QHP members this is likely to include the Marketplace website and written materials. As such, these questions will not be a good measure of plans' performance. We recommend changing the language of these questions to refer to "written material from your health plan" and "your health plan's website" Alternatively, CMS should assess the availability of information on the Marketplace website through the Marketplace survey, rather than including questions in the QHP survey.
    - [BCBS Michigan] Additionally, the first question asks if the respondent looked for information on the Internet about their health plan, but in the follow-up question, it asks how often they found information about **how their health plan works**. We recommend changing the wording of the second question to "In the

last 6 months, how often did the written materials or the Internet provide the information you needed about ~~how~~ your health plan ~~works~~?"

- Question 42 asks whether enrollees have received information or help from their health plan customer service. We recommend revising this question to include those members who needed or unsuccessfully tried to get information from customer service. In its current form, the question limits the subsequent questions to those respondents who received information or help from customer service and may therefore lead to an artificially high "Always" answer rate for question 43, which asks how often did the health plan customer service provide enrollees with the information or help they needed.

    - [BCBS Michigan] We recommend changing the wording of "In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?" to "In the last 6 months, did you get care from more than one health care provider or use more than one health care service?" due to the ambiguity of what a "kind" of service or provider might refer to.

- Question 44 (customer service staff) and question 45 (wait time) both imply that the member successfully contacted customer service by phone, ignoring other possible modes of contact (e.g., the plan's website or email) or outcomes (e.g., could not get through or get a live representative). This is an additional justification to revise the screener question (question 42) to explicitly ask about the number of member attempts to call customer service.
    - [BCBS Michigan] Additionally for Question 45, there is concern about the term "longer than you expected." This will tend to be Usually or Always because a specific time period isn't specified. We suggest changing to 'longer than 10 minutes' or whatever time period reflects the generally acceptable standard wait time for service.

- Question 46 asks how often did health plans provide enrollees with forms to fill out. This question implies that forms can only be given by the plan and enrollees who go online to download claim forms may feel that the question does not apply to them. We recommend revising the question so that the language is broader. For example, the question could be asked, "In the last 6 months, did you have to fill out any forms from your health plan?"
    - [BCBS Michigan] Because Question 46 and the follow-up Question 47 don't identify specific forms, the results would not be useful to health plans or members because no corrective action plans could be targeted.

- Questions 50 and 51 are hard to assess considering there is a low incidence and use of different formatted forms (e.g. Braille). This low incidence and use will translate into a

small sample size which will not be enough to report on health plan level. We suggest deleting these questions to help streamline survey.

- Question 52 asks enrollees to rate their health plan from 0 to 10. Health plans have had difficulties with interpreting CAHPS responses to all rating questions and particularly, question 52. It is difficult for health plans to ascertain what factors such as enrollee experience with claims, customer service, providers or the coverage the plan provides, out of pocket expenses to the member, or public perception of the plan, affect an enrollee's rating.

- Question 53 asks if enrollees would recommend their health plan to their friends and family. Generally, this question is similar to ones plans typically ask their membership. We recommend that this question is reworked to "How likely are you to recommend this health plan to your friends and family?" Additionally, in order to obtain meaningful answers, we recommend that the question response scale is reflective of a zero to 10 scale, with zero being "would not recommend", and 10 representing "would absolutely recommend".

We also have the following concern with questions in the "About You" section of the QHP Survey:

- With the addition of the new health literacy related questions to the "About You" section (question 81, 82 and 83) this section now accounts for almost one-third of all questions in the survey. We believe this extensive set of questions distracts from the purpose of evaluating health plan performance.

- Question 81, more specifically, asks if members had health insurance in the U.S. at any time between January 1 and December 31st of the prior year. However, in order to be eligible for the QHP survey, members have to be enrolled for at least 6 months prior to the time that the survey sample is drawn, with no more than one 30-day gap in coverage. If an issuer typically draw samples in late January/early February, all members receiving the QHP survey have to be enrolled in our plan since August of the prior year. As such, the question currently yields little valuable information. However, if a member was not enrolled in a specific issuer's plan prior to August, it could be informative to know he/she had other coverage. With this understanding, the question should include "did you have other coverage?" or "were you covered by another health plan or insurance before joining our plan?"

- Additionally, the "About You" question responses should be used to inform policy as they do not reflect a health plans behavior.

    - [BCBS Michigan] In the About You section, Q66-69, there are questions regarding daily aspirin use and health conditions the respondent may have or had

had (high cholesterol, heart attack, etc.). These questions may seem too invasive for some respondents (fearing that responses will be shared with the health plan). Some responses may not be truthful.

- [BCBS Michigan] Additionally, Questions 68 and 69 about health conditions ask respondents to "Mark one or more" (implying that at least one condition must be indicated). We suggest changing this to "Mark all that apply" and adding "None" as a response option.
- [BCBS Michigan] For Questions 61 and 65, "don't know" should be removed as an option as people would be able to affirm their answers to these questions. Also, if Q65 is meant to assess aspirin use for cardiovascular benefits, the question should specify this as the reason for use. For example, people with other conditions such as migraines, frequent pain, etc. may take aspirin regularly.
    - "Do you now smoke cigarettes or use tobacco every day, some days, or not at all?" Responses: Yes or No
    - "Do you take aspirin daily or every other day to maintain or improve your heart health (excluding other reasons you may take aspirin)?" Responses: Yes or No

b. Existing CAHPS Clinician and Group Questions

QHP Survey questions 12 and 13 focus on culturally and linguistically appropriate care and specifically whether enrollees needed an interpreter to speak with anyone at their doctor's office, and how often an enrollee received an interpreter at their doctor's office. Incorporating questions about interpretive services into the English version of the survey may lead to a low response rate for these questions because we expect very few English speaking respondents to request such services. These two questions are more appropriate for the Spanish or Mandarin versions of the survey.

Additionally, questions 12 and 13 may cause confusion for the enrollee. The regulatory requirement to supply interpreter services in a provider's office is directed at the physician and we believe the intent of the questions is to ask about interpreter services provided by the doctor's office or clinic. Many times a patient relies on a family member to be the interpreter and as a result, an enrollee who indicates in question 12 that they need an interpreter, may respond that they received one if a family member or friend interpreted for them. This would undermine the value of the questions and CMS should engage in further cognitive testing of these questions and revise them as needed before incorporating them as part of the survey.

CMS also needs to consider whether these questions should be revised to evaluate health plan customer service relative to culturally and linguistically appropriate care rather than focusing on care in the physician office, as some health plans currently provide members with interpreter services to help them communicate with their health care providers. These revised questions could be used to augment existing survey question such as question 49 regarding availability of

health plan forms in the language enrollees prefer. Additionally, we recommend that these questions be tailored to align with the accessibility standards (45 CFR 155.205(c)) to ensure access for individuals with limited English proficiency and individuals with disabilities. The revised questions should also be subject to reliability and validity testing so that a low response rate does not skew the survey results.

c. Non-CAHPS Questions Written for QHP Survey

QHP questions 54-57 pertain to information relating to affordability such as the enrollee's cost of services and any unexpected incurred costs and appear to have been re-introduced to the QHP survey for 2016. These questions raise several concerns, are vaguely written and do not address affordability relative to a QHP, as an enrollee's answers are dependent upon benefit packages and eligibility for the premium tax credit and cost-sharing reductions. As such we recommend that they are not included in the survey.

For example, question 54 asks whether a health plan has refused to pay for a service the enrollee's doctor said they needed. We are concerned that the language "not pay" will be misinterpreted by someone who is new to coverage and will also negatively bias responses. Services need to be part of the benefit package in order to be reimbursed and also enrollee dissatisfaction with a deductible may appear to be non-coverage to a new enrollee.

Additionally, questions 55-57 seek to determine whether an enrollee experienced unexpected costs associated with care and if the enrollee delayed or did not visit the doctor or fill a prescription due to cost. This language is vague and an enrollee's response may be confounded due to the clinical course of treatment and unexpected complications. An alternative approach towards gauging perceptions of affordability could be to ask "how often were you surprised by a medical bill."

Furthermore, many of the elements which explore the perceptions of plan affordability were established as part of the plan designs mandated by the Affordable Care Act (e.g., actuarial value limits). Survey responses may demonstrate a lack of understanding of health insurance, the ACA, and the benefit structure of the QHPs. We recommend these questions are not added to the 2016 survey. As a fallback, if CMS believes there are important policy questions that can be answered by these questions, the responses should not be indicative of plan performance and may be better addressed in the Marketplace survey or considerably reworded.

d. Case-Mix Adjustment Questions

Case-mix adjustment of enrollee responses to the QHP survey can provide for more valid comparisons across health plans than unadjusted surveys by controlling for factors related to response bias. While we are supportive of the current set of case-mix adjustment questions, we recommend additional questions to account for potential variation in responses that may not reflect real differences in QHP enrollee satisfaction.

First, we recommend that CMS assess whether satisfaction differences exist across those who have not previously had insurance, and determine if the surveys should account for these differences. Second, given the uncertainty of reporting enrollee satisfaction at the QHP or metal level, we recommend CMS further study the survey sampling methodology and satisfaction differences across the metals levels to best account for the potential differences in enrollee satisfaction across the four metal tiers and catastrophic QHP plans. For example, an enrollee who selects a bronze plan with a lower actuarial value and higher out-of-pocket limits may be less satisfied with their QHP resulting in lower plan rating than an enrollee who selects a platinum plan. In the alternative, CMS could report scores at the different metal levels to account for any potential satisfaction differences across the metal tiers. Third, we believe it would also be useful to ask if an enrollee has received an Advance Premium Tax Credit. This will assist in identifying whether a QHP population consists of low-income enrollees and the potential impact of the tax credit. Also for transparency purposes, the validity and reliability testing results of newly developed questions should be shared during a future public comment period.

Finally, we also request clarification on case-mix adjustments for plans that enroll significantly large numbers of members who are enrolled for periods of less than three or six months. It is likely that plans experiencing churn with Medicaid and CHIP are more likely to enroll individuals with shorter enrollment spans and this may impact survey results.

e. Cover Letter

As it concerns the QHP Survey Cover Letter, we believe that there may be some confusion with the intent and use of the term "health plan." The second paragraph reads, "If you are enrolled in a different health plan for 2015, please answer the questions in the survey thinking about your experiences in your previous health plan from July through December 2014." While some consumer may switch insurers, others may change metal tiers within the same issuer. Clarification with respect to issuer and metal tier will help survey respondents more accurately identify how they would like to respond.

f. Survey Format

As mentioned previously, Issuers have reported early results from the 2015 beta test that indicated a much lower than expected response rate. As CMS considers ways to increase survey response rates, a better understanding of transient populations may help target likely respondents. Furthermore, assessing the feasibility of internet and or mobile based survey and subsequent implementation of a "paperless" survey option may be needed to increase response rates, understanding the need to maintain electronic security of personal information.

g. Disenrollment Survey

While CMS continues to refine the QHP Enrollee Experience Survey, we recommend that CMS not proceed at this time with the initial assessment and development of a QHP Disenrollment Survey. Furthermore, we discourage CMS from using Medicare Advantage Disenrollment questions for the QHP population since these populations differ. Screening questions for this

population will have to be very precise which will be challenging to develop since the assessment of populations is premature due to continued changes in eligibility and plan choice.

AHIP and its members remain committed to well functioning Marketplaces, QHP implementation and evaluation efforts. Please feel free to contact me if you have any questions.

Sincerely,

Carmella Bocchino
Executive Vice President

June 23, 2015

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Attn: Document Identifier/OMB Control Number CMS–10488
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-10488 - Blue Cross Blue Shield of Michigan Addendum to June 19, 2015 Letter Submitted by AHIP regarding Health Insurance Marketplace Consumer Experience Surveys: Qualified Health Plan Enrollee Experience Survey

Submitted by Blue Cross Blue Shield of Michigan's Market Research team via email to: http://www.regulations.gov

Dear Sir or Madam:

Blue Cross Blue Shield of Michigan agrees with the comments submitted in the June 19, 2015 letter by America's Health Insurance Plans (AHIP) in response to the Centers for Medicare and Medicaid Services' Comment Request for QHP Enrollee Satisfaction Survey Data Collection. We have additional comments about the survey and data collection process that we noted in the AHIP letter and other comments as outlined below.

Regarding OMB No. 0938-1221, Qualified Health Plan Enrollee Experience Survey, Supporting Statement – Part B:

- In section 2, it states that "Weights are generated for each case by multiplying the inverse of the enrollee's probability of selection by the enrollee's probability of response. The enrollee's **probability of selection** is calculated using a logistic regression that includes sampling unit, age, race, eligibility for the Advance Premium Tax Credit (APTC), and other variables." We believe that the second sentence is referring to the enrollee's probability of response, not the probability of selection. Please clarify.

Regarding OMB No. 0938-1221, Qualified Health Plan Enrollee Experience Survey:

General Comments on the survey

- We have a general concern with the Never/Sometimes/Usually/Always scale used in many of the questions. Considering that the surveyed time period is only regarding the last 6 months, many of the experiences asked about may have only occurred once or twice, if at all. For that reason, we recommend changing questions where applicable to a Yes/No scale. For example:
    - "In the last 6 months, did you and your personal doctor talk about all the prescription medicines you were taking?"
    - "In the last 6 months, were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

Comments about: Your Health Care in the Last 6 Months

- With regards to the survey section entitled "Your Health Care in the Last 6 Months," questions 3-9 are asked first about care received "in a clinic, emergency room, or doctor's office," or about care received "at a doctor's office or clinic." The definition of "clinic" may be unclear to respondents. The term "urgent care" should be used in questions 3 and 9 if the intention is to capture visits in urgent care facilities, as well as emergency rooms, doctor's offices, and other clinics.

Comments about: Personal Doctor

- The first question in the "Your Personal Doctor" section defines a "personal doctor" as "the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt." This definition does not necessarily differentiate between doctors seen in any care facility (urgent care clinic, ER, etc.)? If there needs to be a distinction, we suggest including the term "primary care physician" or making reference to the regularity or frequency of contact with that provider; i.e. "the one you would **normally** (or **typically**) see if you need a check-up…"?
- In the question "In the last 6 months, did you take any prescription medicine?" we recommend including a brief definition of prescription (as opposed to OTC) medicine.

Comments about: About You

- In Question 70, respondents are asked if they have received health care "3 or more times for the same condition or problem" followed by "Is this a condition or problem that has lasted for at least 3 months? *Do **not** include pregnancy or menopause*." Should the pregnancy/menopause disclaimer be moved or added to the first question, or is the intention to capture pregnancy and menopause as conditions for the first question?
- In Question 82, "How confident are you that you understand health insurance terms," it may be necessary to offer examples of "terms" – such as co-pay, co-insurance, referral, etc. to help focus responses on specific items, thereby making results more useful.

Sincerely,

Market Research Team
Blue Cross Blue Shield of Michigan