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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, 80 Fed. Register 23556 (April 28, 2015)

Dear Sir or Madam:

Anthem, Inc. appreciates this opportunity to provide comments 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). Section 1311(c)(4) of the Affordable Care Act (ACA) requires the development of an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through the Exchanges (Marketplaces).

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With nearly 71 million people served by its affiliated companies, including more than 38 million enrolled in its family of health plans, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit www.antheminc.com/companies

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, we have devoted significant time and effort in reviewing the survey instruments that will assess consumer experience with the Marketplaces and the QHPs.

The QHP Enrollee Satisfaction Survey posted on the CMS website contains a few 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. 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. We are supportive of CMS' use of the CAHPS principles for developing the QHP and Marketplace Surveys, as well as survey topics such as enrollee experience and customer service. Some of Anthem's recommendations are to:

- Clarify the survey methodology and indicate whether (and, if so, how) the survey sample will be selected to ensure the same person does not get both the Marketplace and the QHP 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;

- Include metal level as a variable of analysis; and

- Help ensure stability of the measures reported by maintaining consistency of the survey questions.

We also offer the following set of comments specific to questions from 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.

- ***Survey Length*** - We are concerned with the length of the survey as it contains 85 questions up from 76 in last year's survey. We recommend CMS taper down the number of survey questions to improve survey participation rate. CMS should use the results of the pilot test to limit the number of questions to ensure that the survey is a reasonable length which will improve survey completion rates. Also, we advocate for the opportunity to add a small number of custom EES questions to assist in cultural and linguistic reporting.
- ***Response Rate*** - CMS is proposing to sample 800 eligible enrollees which are estimated to result in approximately 300 responses per reporting unit based on the 37.2 percent response. In the 2015 Marketplace EES beta-test a health plan had to meet a threshold of at least 500 members as of July 1, 2014. Surveys were sent to 1,000 members or fewer, depending on the eligible membership. Anthem's experience with the 2015 survey across all its plans only yielded an average of a 26.4 percent response rate.
    - **Is CMS reducing the number of surveys to 800 or does the health plan have to meet a threshold of 800 eligible members and send 1,000 surveys depending on the eligible membership?** If the intent is to reduce the sample

from 1,000 surveys to 800, we are not clear how decreasing the sample size will increase response rates. We recommend CMS increase its sample size to increase the number of completed surveys to improve the validity of the survey results**.**

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 questions that capture information about the quality of the plan's provider network and that are applicable to areas that a health plan can directly influence. A health plan's ability to influence clinicians can vary by type of provider. For example, the ACA requires health plans to include specific providers in their network who may not have previously contracted with private health insurers and thus may not have been part of performance reporting and consumer reviews (e.g., essential community providers). Additionally, those providers may not initially have the capacity to undertake quality improvement efforts needed to promote quality and patient satisfaction.

Moreover, 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.

- 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.

- 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.

- 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?"

- 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 about recommending the health plan to friends and family. We suggest this question be rated on a scale of 1 to 10 to allow for NPS (net promoter score) alignment if the health plan so chooses.

- Question 54 asks about services not paid by the health plan and Question 55 asks about services they had to pay for. Those new to coverage may have unrealistic expectations of coverage. In addition, those changing plans may have had broader coverage from their prior plan. We believe these questions are too subjective and should be eliminated or re-worded.

- Questions 56 and 57 asks if an enrollee is 'worried' about cost of services. Anthem questions the inclusion of these specific questions as the term 'worried' is a broad term. CMS should consider adding follow-up questions to both Question 56 and Question 57 such as 'did you investigate the costs by going on-line' or 'did you talk with member services to confirm.'

- Question 77 asks about employment status. We don't believe that including student and home maker as distinct categories of employment status is appropriate. Those should be included in the 'Other' option.

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 just shy of one-third of all questions in the survey. We believe this extensive set of questions distracts from the purpose of evaluating plan performance.

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 questions 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.

Finally, we advocate for the opportunity to add a small number of custom EES questions to assist in cultural and linguistic reporting.

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.

First, questions 54-57 are vaguely written and do not address affordability relative to a QHP, as an enrollee's answers are dependent upon benefit packages. We recommend these questions be redrafted. 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. For example, services need to be part of the benefit package in order to be reimbursed and in addition enrollee dissatisfaction when a deductible is imposed may appear to be non-coverage to a new enrollee. We recommend question 54 be reworded to avoid bias and clarified as to the intended purpose.

Second, questions 55-57 seek to determine whether an enrollee experienced unexpected costs associated with care, and also whether 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. CMS should revise these questions to improve clarity.

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 a 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.

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Anthem is committed to well-functioning Marketplaces, QHP implementation and evaluation efforts. Should you have any questions or wish to discuss our comments further, please contact Alison Armstrong at Alison.Armstrong@Anthem.com or (805) 336-5072.

Sincerely,

Anthony Mader
Vice President, Public Policy