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Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Attn: CMS-10488/OMB Control Number 0938-NEW
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-10488: Enrollee Satisfaction Survey Data Collection (OCN-0938-NEW)

Submitted electronically: 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 June 28, 2013. 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 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 Survey. 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) for health plan accreditation, and is also used by many public and private purchasers. In light of their 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.

We appreciate HHS' intent to establish separate surveys to assess consumer experience with the Marketplaces and the QHPs. In order to be meaningful to consumers, it is critical that the survey instruments 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; however, we have several recommendations applicable to both surveys:

- Clarify the survey methodology and specifically indicate how the survey sample is selected to ensure the same person does not get both the Marketplace and the QHP survey;
- Account for any satisfaction differences across metal levels;
- Ensure accuracy of the survey results through validity and reliability testing of the survey tool and results;
- Help ensure stability of the measures reported by maintaining consistency of the survey questions; and
- Conduct cognitive testing of questions especially those that are new to CAHPS.

We also offer the following set of comments specific to questions from QHP and Marketplace Surveys.

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 questions for the QHP survey that do not have a CAHPS survey indicator, we have several overarching concerns with this survey.

We are concerned with the length of the survey as it is 83 questions long. Currently, it is challenging to obtain question level completeness of the adult Medicaid CAHPS, which has 57 questions. Also, the QHP scoring methodology needs to take into account substantively meaningful differences between levels of plan performance. If plans' scores prove to be very tightly clustered, then CMS should reconsider whether a measure adequately provides consumers with the information needed to identify high quality plans.

a. Existing CAHPS Health Plan Questions

QHP Survey questions 12-29 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

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 can vary by type of provider. For example, 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. Additionally, such providers may not initially have the capacity to undertake quality improvement efforts needed to promote quality and patient satisfaction.

Similarly, to the extent health plans can facilitate communication and care coordination between health care providers and services, it is appropriate to measure and report metrics to consumers. Questions 18-19 and 27-29 address coordination of care among providers and similar questions are currently part of the Medicare CAHPS survey and are also used to calculate the care coordination composite measure. We recommend revising these questions as follows: 1) Combine question 18 and question 27 into a single screener question to establish that the enrollee received care from other providers; and 2) Ensure that questions 19, 28, and 29 appear sequentially in the survey as they are focused on the same topic area.

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

- Questions 34 and 35 ask about written materials or Internet information about health plans. We recommend adapting the language of these questions so that they are tailored to the Exchange environment, as health plan-related information would presumably be available on the Exchange website. Alternatively, CMS could develop a new measure or set of measures assessing the availability of information on the Exchange website as opposed to the materials offered on the plan website.
- Question 40 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 41, which asks how often did the health plan customer service provide enrollees with the information or help they needed.
- Question 42 (customer service staff) and question 43 (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 40) to explicitly ask about member attempts to call customer service. We also recommend adding a question or series of questions to capture the mode

of contact used as well as the outcome of the call (e.g., spoke to a live rep, left message, on hold too long, etc.). This will help to more precisely define the appropriate respondent base for questions 42 and 43.

- Question 44 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, however, it should. 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?" This change will also make the wording more consistent with the language of question 45 and question 46.
- Question 50 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 50. It is difficult for health plans to ascertain whether the driver of an enrollee's rating is 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. In order to help health plans identify and concentrate on areas that need improvement, we recommend including additional questions such as, "What is most important to you when rating your plan?" We also recommend that health plans have the opportunity to include supplemental and unpublished questions to gather additional information for quality improvement.

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

- Questions 63 through 65 are aspirin measures. We recommend removing this set of questions as the National Committee on Quality Assurance has documented methodological concerns with aspirin measures and does not report these results.
- Questions 76 and 77 assess race and ethnicity and we recommend that these questions be revised to reflect the standards required by Section 4302 of the Affordable Care Act for collecting data on race and ethnicity in population health surveys sponsored by HHS. The final standards include four granular levels for Hispanic (e.g. Mexican/Mexican American/Chicano(a), Puerto Rican, Cuban and Another Hispanic, Latino or Spanish Origin) and seven Asian subpopulations that can be rolled up to the OMB categories.

b. New CAHPS Clinician and Group Questions

QHP Survey questions 10 and 11 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 10 and 11 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 10 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. Also, we recommend that if the answer to question 10 is "No" that the enrollee should skip question 11.

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 46 (regarding availability of health plan forms in the language enrollees prefer) and question 41 (regarding giving members the information/help they need). 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 51-55 pertain to information relating to affordability such as the enrollee's cost of services and any unexpected incurred costs. These are non-CAHPS based questions that were developed for the QHP survey, with the exception of question #51, and raise several concerns.

First, questions 51-55 are vaguely written and do not address affordability relative to a QHP, as an enrollee's answers are dependent upon benefits packages. We recommend these questions be re-drafted. For example, question 51 asks an enrollee how often the health plan made it clear how much the enrollee would have to pay. It is unclear whether this question is asking about the cost of a service or the cost of the enrollee's premium. Additionally, it presupposes enrollees are contacting health plans to ascertain their costs associated with services and implies a level of perfect knowledge of what services they will need in a given timeframe.

Second, question 52 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 "refuse to 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 also enrollee dissatisfaction with a deductible may appear to be non-coverage to a new enrollee. We recommend question 52 be reworded to avoid bias and clarified as to the intended purpose.

Third, questions 53-55 seek to determine whether an enrollee experienced unexpected costs associated with care and also 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. CMS should revise these questions to improve clarity.

We recommend that questions 51 through 53 be revised to address these concerns. Additionally, we recommend moving questions 54 and 55 to the Marketplace Survey in order to determine the affordability of coverage. We note that the questions would need to be revised to take into account that the Marketplace user may not have had any past experience with the health care system.

Questions 43 and 80-81 are also non-CAHPS based questions that focus on wait time to talk with the health plan's customer service, previous health insurance coverage, and previous coverage by medical assistance programs. We recommend revising these questions to include a time reference or reporting frequency, similar to the other questions in the QHP Survey. More specifically, we recommend revising question 43 as it is vaguely written, the wording may introduce a negative bias against health plan service level, and enrollees may have varying expectations of how long it should take to speak with the health plan's customer service representative. Question 80 should also be revised for clarity as currently it is written "Have you had been covered by health insurance." and contains an extraneous word.

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 adding a question that assesses the enrollee's insurance status prior to enrolling in a QHP. 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, while we appreciate the inclusion of a question that asks whether an enrollee was covered by Medicaid in the past 5 years, we believe it would also be useful to ask if an enrollee is or has received an Advance Premium Tax Credit. This will assist in identifying whether a QHP population consists of low-income enrollees. Similarly, we would also recommend that CMS add a question that could be used to adjust for disability/mobility impairment and presence of another individual in the home (e.g. caregiver, spouse) to identify whether a population is made up of more respondents with significant health care needs. Also for transparency purposes, the validity and reliability testing results of newly developed questions should be shared during a future public comment period.

II. Comments on the Marketplace Survey Questions

The Marketplace Survey includes topics to assess enrollee experience with the Marketplace, such as customer service, enrollment, and obtaining information on the Marketplace website. While we are supportive of this survey, we are concerned that the questions may result in unfairly tying the enrollee shopping experience to a QHP, when the experience is affected by multiple channels, plans, and people. To help address this, we recommend adding a series of questions about enrollees experience with Exchange Navigators.

Additionally, Marketplace Survey questions 7 and 8 ask whether enrollees qualified for Medicaid or the Advanced Premium Tax Credit. While we are supportive of these questions, we recommend including "Don't Know" as an answer option. Only having "Yes" or "No" options when asking if enrollees qualify for complex government coverage does not seem to operate at an 8th grade or below level, which is required for government programs.

Marketplaces Survey questions 28-35 assess an enrollee's experience seeking in-person information and reference "customer service staff." We are concerned that this set of questions is vague as it is not clear who and what is being evaluated. Many avenues for Marketplace enrollment will exist and will vary across states. In addition, in the Federally-facilitated Marketplace health plans can facilitate the enrollment process. Due to these multiple avenues of enrollment, it would be very unlikely that an enrollee would be able to differentiate between the enrollment process that occurs at the Marketplace website, which is where enrollees select their specific QHP and receive an eligibility determination, versus the health plan process where the health plan is receiving information directly from the Marketplace.

We recommend this set of questions be modified so the language clearly focuses on the Marketplace customer service and experience and not health plan facilitation efforts and

processes. Also, including a clear definition of "customer service" in the question may help enrollees differentiate between Marketplace enrollment and any health plan process. Cognitive testing should be conducted around how enrollees interpret and respond to these questions and testing results should be shared during a future public comment period.

It is also unclear what question 40 is trying to measure and more specifically what is meant by the term "quality." We recommend giving an example or definition of "quality" as the average enrollee is likely to not know or have varying definitions.

Additionally, question 49 asks enrollees to rate their health plan enrollment process. We are concerned that this question is too vague and is it unclear whether this question is asking about health plan facilitated enrollment or enrollment through the Marketplace website. We recommend revising this question or providing a definition for "health plan enrollment process" so that it is understandable to enrollees.

Question 63 asks whether the enrollee is employed full-time, part-time, or not employed. We recommend adding answer options to this question such as: full-time outside of the home, part-time outside of the home, working but not outside of the home, and not working-other.

We also recommend the following editorial revisions:

- Revise the wording of questions 39, 41, and 43 (i.e. "how often was it easy") so that they are less awkward and easier to understand;
- Include "Other" in the list of options in question 45 since the entire tax household is considered together for advance premium tax credit and may include people other than self, spouse, and children. Also, the statement "Mark one or more" should be revised to "Mark all that apply" and in bold font; and
- Revise the wording of question 69 (i.e. "Have you had been covered") as it contains an extraneous word.

AHIP remains committed to successful Marketplace and QHP implementation and evaluation efforts. Please feel free to contact me if you have any questions.

Sincerely,

Carmella Bocchino
Executive Vice President