BlueCross BlueShield Association

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Centers for Medicare and Medicaid Services (CMS)
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard, Baltimore,
Maryland 21244–1850.

RE: **Agency Information Collection Activities: Proposed Collection; Comment Request—Enrollee Satisfaction Survey Data Collection (**CMS-10488)

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Dear Ms. Jones:

The Blue Cross and Blue Shield Association (BCBSA) – representing the 37 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide health coverage for 100 million members, one in three Americans – appreciates the opportunity to submit comments on the Notice: "Agency Information Collection Activities: Proposed Collection; Comment Request," as issued in the *Federal Register* on June 28, 2013 [*78 Fed. Reg. 38986*].

We are commenting on the two assessment surveys comprising the Information Request for "Enrollee Satisfaction Survey Data Collection": (1) Survey of adult enrollees in Qualified Health Plans (QHPs); and (2) Survey of health insurance Marketplace consumers. Our comments focus primarily on ways to enhance the quality, utility, and clarity of the information to be collected.

Last year BCBSA responded to CMS's June 2012 "Request for Domains, Instruments, and Measures for Development of a Standardized Instrument for Use in Public Reporting of Enrollee Satisfaction with Their Qualified Health Plan and Exchange." We appreciate CMS's favorable response to many of our recommendations, among them the decisions to:

- Build on the current CAHPS health plan survey.

- Split the enrollee satisfaction questions from questions that relate to consumers' interaction with the Marketplace.

- Use a six-month look-back period rather than the standard 12-months as in the current CAHPS survey.

- Enhance "Your Health Plan" to include specific inquiries around where patients go to look for information, the type of information sought, whether they found the information and whether the language was linguistically appropriate.

- Add questions concerning previous insurance coverage – likely to influence individuals' health literacy or knowledge of quality care – to "About You."

However, we believe that CMS should improve the draft QHP survey still further, before the June 2014 field test, to enhance the validity, reliability, and utility of information gathered from the survey. We have four overarching methodological concerns:

- ***Survey length.*** We recommend removing questions that are not absolutely essential for assessing enrollees' satisfaction with their health plan to minimize administrative burden and maximize response rates.

- ***Health Literacy.*** We recommend explicitly including one or more questions to assess the health literacy of respondents to provide a more accurate assessment of enrollees' satisfaction with health plan and provider services.

- ***Sampling/reporting units.*** We recommend simplifying the sampling method to define reporting entities and sampling units to avoid, on the one hand, situations where plans needlessly pay for duplicative surveys and, on the other hand, situations where surveys are not conducted because of enrollment limitations.

- ***Assessment score adjustments.*** We recommend clarifying that the CAHPS-based enrollee satisfaction scores will be case mix adjusted, just as CMS plans to case-mix adjust the Marketplace survey scores, to make fair comparisons among QHPs.

Regarding the draft Marketplace survey, we have the following general recommendations:

- ***Application process.*** We recommend adding information that tracks how consumers enrolled in the marketplace.

- ***Ambiguous/Inconsistent language****.* We recommend reconsidering the wording of a small subset of questions to help avoid confusion and provide more meaningful responses.

- ***Survey Length.*** As with the QHP survey, we recommend removing questions that are absolutely not essential for assessing enrollees' satisfaction with their marketplace experience to minimize administrative burden and maximize response rates.

In what follows, we offer detailed comments on the QHP survey (first the methodological issues mentioned above and then section-by-section recommendations regarding specific questions), and then on the Marketplace survey.

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QUALIFIED HEALTH PLAN ENROLLEE SATISFACTION SURVEY

Methodology

Issue. CMS indicates it will make every effort to maximize the response rates (expected to average 40% overall), and "Health Insurance Marketplace Enrollee Satisfaction Surveys: Supporting Statement—Part B, Collections of Information Employing Statistical Methods" proposes a number of valid, commendable steps. But of all the things that could affect responding (appearance of the survey, affiliation with the requester, perceived value, timing, types of questions, etc.), the length of the survey is one major driver behind response rates.[1] At 83 questions, the survey is long and runs considerable risk of fatiguing respondents and causing reduced response rates.

Recommendation. Delete questions that are not absolutely essential for assessing enrollees' satisfaction with their health plan, or where the incremental value of the question is not worth the possible drop in response rates. Throughout the succeeding section-by-section comments, we indicate which questions merit deleting.

Rationale. At 83 questions, the survey is long and runs considerable risk of fatiguing respondents and causing reduced response rates. If the incremental value of the question is not worth the possible drop in response rates, CMS should delete it from the CAHPS survey, especially since additional questions are needed to flesh out gaps in other questions or domains.

Issue. The Supporting Statement-Part B notes that "the tentative plan is to sample individuals to receive mail surveys." This differs from the Marketplace survey where CMS plans to test "the equivalence of the survey *measurement properties* in two modes of administration – mail and telephone." In neither case is CMS testing an online mode of administration.

Recommendation. As part of field test, test online mode of administration (in conjunction with mail and telephone modes).

Rationale. By testing a mixed-mode survey design that incorporates online surveys in conjunction with traditional survey methods such as telephone and mail, this will offer different options for completing the survey that will appeal to the diverse makeup of the Marketplace population.

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[1] "Swat IR", *Swarthmore College Research Blog*, August 21, 2013, http://blogs.swarthmore.edu/institutional-research/?p=19 .

Issue. As part of the information collection procedure, CMS plans to send an advance mail letter, which CMS believes will help to maximize response rates.

Recommendation. Delete the advance letter.

Rationale. The advance letter is not likely to increase the response rate an appreciable amount. Indeed, recent research shows that an advance letter was not seen to be effective in increasing response or cooperation rates in a nationwide telephone survey [J Clin Epidemiol. 2013 Jun 1. *An advance letter did not increase the response rates in a telephone survey: a randomized trial.*
Carey RN, Reid A, Driscoll TR, Glass DC, Benke G, Fritschi L.] The cost of sending the advance letter is not worth the benefit.

Issue. Health services research shows that limited health literacy is related not only to poorer health outcomes, but also to higher levels of patient dissatisfaction. Patients with low health literacy may express higher levels of dissatisfaction than those with higher literacy. If low health literacy contributes to varying satisfaction scores among QHPs, assessing causation will be difficult until enough time has passed to provide a robust longitudinal database (e.g., is unequal quality of communication and service across QHPs contributing to variations in satisfaction, or is the main contributor the unequal distribution of literate enrollees?).

Previous research has found that a single question, "How confident are you filling out medical forms by yourself?" is useful for detecting patients with inadequate health literacy.[2] Two other screening questions have also achieved high validity: (1) "How often do you have problems learning about your medical condition because of difficulty understanding written information?"; and (2) "How often do you have someone like a family member, friend, hospital or clinic worker or caregiver, help you read hospital or clinic materials?" In addition, studies suggest that low English proficiency in and of itself is associated with higher rates of low health literacy, which makes it important to include questions about one's English proficiency.[3]

The draft survey contains similar questions, but the placement and wording of these questions creates ambiguity:

- Q. 10 provides some insight into the enrollee's English proficiency, though it may have limited utility because of the 6-month look-back period.
- Q. 45's intent seems to be to measure the quality of the health plan's forms since it is included among other questions about health plan service. However, it may

[2] J Gen Intern Med. 2008 May; 23(5):561-6.Validation of screening questions for limited health literacy in a large VA outpatient population. Chew LD, Griffin JM, Partin MR, Noorbaloochi S, Grill JP, Snyder A, Bradley KA, Nugent SM, Baines AD, Vanryn M.

[3] Matthew K. Wynia, MD, MPH[1] and Chandra Y. Osborn, Health Literacy and Communication Quality in Health Care Organizations, J Health Commun. 2010; 15(Suppl 2): 102–115.

be impossible to determine whether a health plan's forms are never easy to fill out because of poorly written forms, or because the enrollee has low health literacy.

- Q. 82 may say more about problems with the survey than with the quality of a plan's or its providers' communications.

Recommendation. Eliminate Q. 82 and replace with the following questions at the end of the survey:

- How confident are you filling out medical forms by yourself?
- How often do you have someone like a family member, friend, health plan, hospital or clinic worker or caregiver, help you read health plan, hospital or clinic materials?
- How often do you have problems learning about your medical condition because of difficulty understanding written information?
- Revise Q. 83: If someone helped you complete this survey, how did that person help you?

Rationale. Measuring health literacy will help consumers make better choices among health plans if plans' satisfaction scores are related to disproportionate enrollment of low-literacy or high-literacy members; it will provide actionable information that QHPs can use to improve their interactions with members; and in any case-mix adjustment, health literacy makes sense conceptually. These previously validated questions should detect problems with health literacy that are not due to low English proficiency. They will also help clarify ambiguities around Q. 45.

Issue. The Supporting Statement—Part B clarifies that the reporting entity is based on a combination of issuer, product, and plan (identified by different metal levels), and that the 4-digit Standard Component ID number will be used to define the accountable unit (to define reporting entities and sampling units. However, in some cases this approach may needlessly raise costs by forcing health plans to pay for duplicative surveys; in other cases, fragmented enrollment across QHP variations may preclude needed surveys.

Recommendation. Modify the accountable unit to apply to pre-defined product types (e.g., HMO, PPO, POS). Plans would group all of their QHP products that belong to the HMO product-type, PPO-product types, etc., and samples would be drawn from each metal level for that product type.

Rationale. Basing sampling on the Standard Component ID could be problematic because in some cases it will burden plans with unnecessary costs by conducting duplicative surveys. For example:

- If an issuer offers a Silver HMO that is health-only, and one that has dental-embedded, then that Silver HMO requires two Standard Component IDs. If both HMOs had more than 500 enrollees, the Plan would have to pay for two separate

surveys, which would be duplicative and needlessly costly because the only difference between the two QHPs is a unique benefit that is not even addressed in the survey.

- If an issuer offers two Silver PPOs that are identical except for the mix of deductibles and copay (e.g., one Silver PPO has a relatively high deductible and lower copays, the other has a relatively low deductible but commensurately higher copays), even though the two PPOs have identical actuarial values and rates the issuer may need different Component ID. Again, requiring two separate surveys would be duplicative and needlessly costly because apart from modest cost-sharing differences that have no effect on premium rates or average out-of-pocket costs, the PPOs are otherwise identical.

The costs associated with such duplicative surveys could be significant considering that issuers may have scores of QHP products with Standard Component IDs. For example, one Blue Plan in a federally-facilitated Marketplace has 54 Plan IDs (without cost-sharing variation).

In other cases, the sampling scheme would produce the absurd result of precluding any surveys. For example, the ACA directs that the enrollee satisfaction survey will ‘‘evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each qualified health plan that had more than 500 enrollees in the previous year.’’ Moreover, assuming an overall response rate of 40%, CMS assumes that vendors will need to draw samples of 750 from each reporting entity.

- If a Plan offers a Silver HMO that is health-only and has 400 members, and a Silver HMO that has dental-embedded and 400 members, the sampling methodology would preclude any survey, even though together the two separately identified HMOs – identical but for the dental benefit – would collectively permit drawing a sample of 750.

Finally, defining the reporting entities by product-type is consistent with how recognized accrediting entities define reporting entities under their accreditation programs.

Issue. The Supporting Statement—Part B notes that to make fair comparisons of Marketplaces, scores will be adjusted for patient characteristics such as age, education, overall health rating, gender (case mix adjusted), but includes no mention of a similar adjustment for the CAHPS survey.

Recommendation. CMS should adjust enrollee satisfaction survey results to account for factors that may affect scores for the QHP that are beyond the control of the QHP. As CMS is planning for the Marketplace survey, it should use regression models to select a set of case-mix adjusters from a pool of exogenous predictors (e.g., age, education, overall health rating, gender, and any other variables the make sense conceptually such as previous insurance coverage or health literacy) and estimate the predictive power and heterogeneity of the adjusters (using regression and variance component models).

Rationale: It is well established that CAHPS can be adjusted – and in Medicare Advantage CAHPS scores are adjusted – to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey

responses.[4] Adjusting CAHPS scores would be consistent with current practices in Medicare Advantage and in the Marketplace survey, and ensure fair comparisons.

Issue. In general, surveys should not force people into answering questions when they are not certain. However, the draft survey makes very sparing use of "Don't know" as a response (sometimes as part of a skip pattern as in Q. 47, and sometimes simply as an answer as in Q. 58). A related issue concerns questions that people may feel uncomfortable answering, such as race, which is why survey research firms typically give people a "Prefer not to answer" option to sensitive personal questions.

Recommendation. Allow a "Don't Know" response to all questions, except to those in which it is virtually certain that all respondents will have a clear answer. For example, Q.21 and Q.48 assume knowledge of what a provider or health plan *should* be doing, but it is not always clear if it was done or what the reference comparison is. In addition, include "Prefer not to answer" as an option for Q. 72, 74, 75 (if retained, see below for recommendation to delete), 76, and 77.

Rationale. These responses are necessary alternatives to avoid frustrated respondents, or making respondents feel coerced into giving an answer they do not want to or simply are not able to give.

Your Health Care in the Last 6 Months

Issue. In our response to the 2012 RFI, we commented that the current CAHPS survey does not elicit sufficient information on the adequacy of a health plan's provider network, either in terms of consumers' ease of finding the right doctor, or in the context of locating a provider who meets patients' particular cultural and linguistic needs. The draft QHP survey adds questions 10 and 11 concerning need for and availability of interpreters, but elicits nothing about the quality of those services, which are an important part of patient-provider communication.

Recommendation. Add a question to rate the interpreter. For example, some Plans have used the following supplemental question to the current CAHPS survey: We want to know your rating of this interpreter, the one provided by this doctor's office that you had most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate the interpreter provided by this doctor's office you had most often in the last 12 months?

*Rationale***.** The added question fills out assessment of cultural competence and linguistic appropriateness, and will help health plans exploit one of the official purposes of the survey, "provide actionable information that the QHPs can use to improve performance."

[4] *About the CAHPS Clinician & Group Survey Database,* AHRQ Contract No.: HHSA 290200710024C (March 2012).

Your Personal Doctor

***Issue*.** In our response to the 2012 RFI, we recommended modifying the section on a "personal doctor" to broaden the scope so that it encompasses non-physician clinicians (e.g., NPs and PAs), and also team-based care that may be offered via innovative care delivery arrangements, such as PCMHs. The draft QHP survey does not change the definition of personal doctor, and is ambiguous and potentially confusing regarding care not received from one's personal doctor (i.e., a yes to Q. 18 could mean that the enrollee received care from a specialist, or that the enrollee received care from a nurse practitioner who was part of the personal doctor's team). Additionally, the survey assumes that care accessed or received is for medical, surgical or behavioral health purposes (and not dental). Since some products that will be offered will include dental coverage, it should be made clear in the survey that the personal doctor is referring to non-dental providers.

Recommendation. Modify Q.12 definition of personal doctor for consistency with new delivery models: A personal doctor is a physician or other health care provider or team of providers you would see if you need a check-up, want advice about a health problem, or get sick or hurt. In addition:

- Eliminate Q. 18 and Q. 19.
- Modify Q. 27 to refer to care received outside the four walls of the personal doctor's office: Did you get care from a health care provider who is not your personal doctor or more than one kind of service that was not provided by your personal doctor?
- Include clarifying language at the beginning of "Your Personal Doctor", "Getting Health Care from Specialists" and "Your Health Care in the Last Six Months" sections that specifies that responses to survey questions should pertain to non-dental providers or health care received.

*Rationale***.** Modifying the definition of personal doctor will account for the fact that a personal doctor may not always be the one providing the care for patients in the newer care delivery models.

Q. 18-19 and Q. 27-29 all seem designed to detect the same concept of care coordination. Modifying Q. 27 as recommended would allow for deleting redundant questions while still assessing the extent of care coordination offered by one's personal doctor.

Clarifying language will help ensure there is no confusion around which provider an enrollee may be evaluating when completing the survey.

Issue. Responses to Q. 23 and Q. 24 are potentially ambiguous if the enrollee did not complete the blood test, x-ray, or other test ordered by the enrollee's personal doctor.

Recommendation. Modify Q. 22: "Did your personal doctor order a blood test, x-ray, or other test for you <u>that you completed?"</u>

Rationale. Since completion of the test or orders is also dependent on patient compliance, if the patient did not get the test/orders performed, Q. 23 and Q.24 are irrelevant.

Issue. It is unclear how Q.29 will be scored: the responses are not consistent with other questions.

Recommendation. Replace current responses with (1) Never; (2) Sometimes; (3) Usually; (4) Always; (5) Don't know.

Rationale. Consistency of response choices will provide for more meaningful analysis and comparison.

Issue. After-hours care is an issue of particular concern to health plans. As new care delivery models emerge, the availability of after-hours care has been shown to help prevent avoidable trips to more costly settings of care, such as the emergency room, for routine health care needs.

Recommendation. Add a question about after-hours care. For example, some Plans currently use the following supplemental question to the current CAHPS survey:

- How often were you able to get the after-hours care that you needed? (Never, Rarely, Sometimes, Usually, Always)

Rationale. Tracking after-hours care will help provide information on the availability of the personal doctor, and how well that doctor is able to meet the patient's needs (when they need it).

Your Health Plan

***Issue*.** As we indicated in our response to the 2012 RFI about the current CAHPS survey, this section still lacks robust overall performance measures addressing health plans: for example, the only question currently designed to capture consumers' overall experience with the health plan (Q. 27) – *How do you rate your plan as the best or worst possible health plan?* – is of limited utility because it is contingent on the respondent's broader experience with health insurers.

Recommendation. Add questions that elicit insight into enrollees' loyalty to their health plan, for example one or more of the following:

- How well does your health plan meet your expectations?
- How likely are you to renew with your health plan?
- How likely are you to recommend your health plan to others?

Rationale. Questions addressing a consumer's loyalty to a health plan provide a far better representation of overall satisfaction than a question that expressly requires drawing on experience with other carriers – a baseline that will vary widely across consumers, and may not be germane to consumers who are newly gaining coverage through the Exchange.

Issue. In our response to the 2012 RFI, we commented that the current CAHPS survey tells little about whether a health plan is providing information that helps its members understand and use their benefits appropriately, and recommended adding questions about the enrollee's efforts to find information about how the plan works. The draft survey improves over the current CAHPS by adding question about one's search for information, but Q. 34 is of limited utility because it does not specify the source of written information, and Q. 36 to 39 are all focused on out-of-pocket costs, an important issue but not necessarily less important than, say, information from one's health plan about the quality of a provider.

Recommendation. Modify Q. 34 to clarify whether the enrollee's search was for written materials on the plan's website:

- **In the last 6 months, did you look for information about how your health plan works (*Please check only one*)?**

  1. Written materials
  2. On my health plan's website
  3. Both written materials and on my health plan's website
  4. Some other place on the Internet
  5. I did not look for information on how my health plan works

Replace Q. 35, Q. 36, and Q. 38 with two questions to detect the type of information sought and the quality of that information:

- **What information did you look for? (*Check all that apply*)**

  1. Benefits
  2. How much to pay for a health care service or equipment.
  3. How much to pay for specific prescription medicines.
  4. The quality of a doctor or hospital.
  5. How to find or see a doctor
  6. Information about a health condition
  7. Community resources
  8. How to contact the health plan
  9. Language help
  10. Transportation help
  11. Other

- **Did you find what you were looking for?**

  1. Yes, and the information was clear and easy to understand
  2. Yes, but the information was not clear and easy to understand
  3. I didn't find what I was looking for.

Rationale. Questions that drill down to how the plan works are critical because they shed light on functions that are within plans' immediate control, and thus provide a robust basis for cross-plan comparison. Capturing a greater level of detail on consumers' direct experience with their health plan will yield results that enable consumers to make more meaningful distinctions among plans based on particular

factors that are a priority to them. For example, consumers may place differential weight on a metric that shows a lack of member satisfaction stemming from problems getting cost or quality information versus problems finding or seeing a doctor. Moreover, more granular questions on enrollees' experience with health plan functions will enable plans to pinpoint and take steps to resolve the causes of satisfaction problems (i.e., provide actionable information that the QHPs can use to improve performance).

Issue. Q. 51 is redundant because it covers the same information as Q. 37. There is little discernible difference between "how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it" and "before you went for care, how often did your health plan make it clear how much you would have to pay?"

Recommendation. Delete Q. 51.

Rationale. Deleting a largely redundant question is in keeping with our overarching concern about including questions that do not add enough incremental value.

Issue. Q. 52 is worded pejoratively – "refused" implies a spiteful unwillingness to comply with a request for coverage, and "that your doctor said you needed" is inflammatory because any claim for service must have been recommended by a doctor – and it is of questionable utility because the wide range of reasons that payment is declined that are not under the control of the plan.

Recommendation: Delete Q. 52. If CMS believes an alternative is required, include a question that detects the quality of the plan's response to a decline of payment: In the last 6 months, if your health plan declined to pay for a service, were you provided an understandable reason?

Rationale: Q. 52 is too ambiguous to provide any meaningful information to make QHP choices For example, the top five reasons that payment is denied for medical claims involve little to no health plan culpability[5]:

1. Duplicate claims. Hospitals and physician practices are all taking part in a common mistake which accounts for the largest percent of claim denials. Front office administrators are hitting resubmit after not hearing back from insurance companies, which resets the clock on the time it takes to pay a claim.

2. Claim lacks information. Human error impacts most practices but nowhere is this more prevalent than in claims processing. Basic information, such as a person's date of birth or spelling of a name, are common mistakes. When these claims are denied, it

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[5] Interview with Brian Fugere, COO of RemitDATA, a comparative analytics provider, with *Healthcare Finance News*, July 31, 2013.

almost always doubles the time it takes to turn around a claim, affecting the practice as well as the patient.

3. Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped.

4. Claim not covered by insurer. Another claim denial that can be avoided with verification is when procedures are not covered by an insurer.

5. Time limit expired. Having the time limit expire on a claim often happens because most practices concentrate on larger claims first, which mean small money claims are put on the backburner. This causes a lot of small claims to be denied.

The recommended alternative question is preferable (though in our opinion not necessary) because "declined" is a more neutral term than "refused" – it is used in the Agencies' model notice of adverse benefit determinations – and it is lacking in the ambiguity inherent in the current question. Therefore, the alternative will better help consumers choose among competing health plans than the original question.

About You

*Issue***.** Q. 58 to Q. 67 ask about the enrollee's medical conditions or use of preventive services, information of questionable relevance to assessing enrollee satisfaction or that is readily obtainable from other sources.

*Recommendation***.** Delete Q. 58 to Q. 67

Rationale. Each of the above questions merits deletion for the following reasons:

- Q. 58—Plan information available through HEDIS Flu vaccinations for adults 18-64.
- Q. 59-62 — Response rates to questions about tobacco use have been so low in commercial CAHPS that NCQA is moving to a two-year rolling average for these measures because of the resulting inadequate sample sizes. Especially in QHPs' early years, these measures are unlikely to yield statistically reliable data.
- Q. 63-65—Whether or not a person with an appropriate health need takes aspirin does not seem relevant to assessing competing health plans because under the preventive services guidelines health plans must cover aspirin without cost-sharing for certain men and women when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm when prescribed by a health care provider.

- Q. 66—High cholesterol information relevant to assessing plans is available through HEDIS (Cholesterol Management for Patients With Cardiovascular Conditions); High blood pressure information is available through HEDIS (Controlling High Blood Pressure).

- Q.67—Heart attack or heart disease information relevant to assessing plans is available through HEDIS (Persistence of Beta-Blocker Treatment After a Heart Attack); Diabetes information is available through HEDIS (Comprehensive Diabetes Care-Screening [Eye Examination, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy], Comprehensive Diabetes Care/HbA1c Poorly Controlled).

***Issue*.** Q. 68 to 71 ask about the enrollee's frequent use of services and use of medicine, information that is ambiguous or superfluous and of questionable utility to assessing enrollees' satisfaction.

Recommendation. Delete Q. 68 to Q. 71

Rationale. Each of the above questions merits deletion for the following reasons:

- Q. 68—Getting care three or more times for the same condition does not necessarily mean that the condition is serious, as when an adult gets repeated allergy shots, or it may be an indication of excessive, inappropriate utilization.

- Q. 69—The question is meaningless without information on severity.

- Q. 70—Redundant to Q. 25.

- Q. 71—The question is meaningless without information on severity.

***Issue*.** It is not clear why Q. 75 (one's employment status) would affect enrollees' health plan satisfaction.

Recommendation. Delete Q. 75.

Rationale. We can think of no reason why one's employment status should affect one's satisfaction with one's health plan. If CMS can offer a cogent rationale, then the proposed responses are deficient. For example, Harris Polling offers the following options:

1. Employed full-time
2. Employed part-time
3. Self-employed full-time
4. Self-employed part-time
5. Temporarily unemployed
6. Full-time homemaker
7. Retired
8. Student
9. Disabled
10. *Prefer not to answer*

Issue. Q. 76 offers inadequate responses.

Recommendation. Revise responses as follows: (1) No, not of Hispanic, Latino, or Spanish origin; (2) Yes, Mexican, Mexican American, Chicano; (3) Yes, Cuban; (4) Yes, another Hispanic, Latino, or Spanish origin; (5) Prefer not to answer

Rationale. Consistent with how national polling firms track this question, the recommendation revision recognizes the significant cultural, SES, etc. differences among various groups.

Issue. In our response to the 2012 RFI, we recommended asking if the enrollee previously lacked health insurance coverage and for how long a period? The draft survey does add Q. 80-81 about previous coverage, but they may be difficult to answer and interpret because they lack a time component.

Recommendation. Revise Q. 80 and 81 to begin, "In the last five years, have you been covered by. . ."

Rationale. Very few people have *never* been covered by health insurance, and Plans' experience in asking similar questions is that consumers' responses become hazy going back more than five years.

Issue. In our response to the 2012 RFI, we recommended asking whether the enrollee was receiving a subsidy (APTC).

Recommendation. Add a question: Are you receiving a subsidy from the government that helps to pay for your health plan premium?

Rationale. Experience in the commercial market is that the extent of the employer's contribution has an effect on members' satisfaction with their health plan. This is a conceptually important variable to include in selecting case mix adjustors.

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MARKETPLACE ENROLLEE SATISFACTION SURVEY

How Consumers Enroll (Application Process)

Issue. The draft survey does not collect any information on *how* consumers enroll in marketplace coverage. Invariably, the enrollment process will shape the consumer's experience of the marketplace.

Recommendation. BCBSA recommends that the survey ask enrollees how they enrolled in marketplace coverage. Specifically:

- Did you receive assistance from a Navigator? [Yes/No]
- Did you receive assistance from an agent or broker? [Yes/No]
- Did you enroll via the marketplace website without any outside assistance? [Yes/No]

- Did you enroll directly with a health plan issuer? [Yes/No]

Rationale. Consumers will be enrolling in marketplaces through multiple channels, including Navigators, Brokers, directly with health plan issuers and directly through the marketplace websites. In evaluating consumers' satisfaction with marketplaces, information about how consumers enroll will help target future improvements and/or interventions.

Ambiguous/Potentially Confusing Questions

Issue. A few questions in the survey are either ambiguously worded or lacking qualifying information that could help elicit more meaningful responses.

Recommendation. Modify the questions below to clarify the following:

- Modify Q. 15, Q.23 and Q.32. The word "provider" was used in these questions, and the average American probably understands the word "doctor" or "doctor or hospital" better than "provider". Replace the word "provider" with "doctor or hospital".

- Modify Q. 28-35 to clarify the difference between customer service staff and navigators. If customer service staff is in fact the same as navigators, the survey should identify them as such.

- Q.4 and Q.48 are similar. From the introduction before Q4, it implies that Q4 includes the application to the health plan along with finding out if you qualify for a subsidy. Those who know they don't qualify for a subsidy and just apply for a health plan will be answering the same question.

- Modify Q. 69 to include a reference to the previous five-year time period as in Q. 68.

- Modify Q. 70 to differentiate how often respondents use the Internet, rather than just a Yes/No response:

    - How often do you access the Internet through a computer, tablet, or smart phone?
        1. Never
        2. Rarely
        3. Sometimes
        4. Frequently
        5. Always

Rationale. Clarifying language will help ensure there is no confusion around terminology used when completing the survey as well as adding more detailed information for comparison.

Length of Survey

Issue. Similar to the QHP survey, the number of questions for the Marketplace survey is a concern. This may lead to administrative burden for consumers and poor response rates.

Recommendation. CMS should review research on consumer experience to assess whether the current survey instrument balances the desire to collect the maximum amount of relevant data with the likelihood that consumer response to the survey will be sufficient for reliability.

Rationale. If the survey is too long, consumers may not complete the survey, and CMS may not obtain the data needed to refine marketplace processes going forward. We recommend removing questions that are not absolutely essential for assessing enrollees' satisfaction with their marketplace experience to minimize administrative burden and maximize response rates.

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We appreciate your consideration of our comments. We look forward to continuing to work with CMS on issues related to assessing enrollee satisfaction with their qualified health plan and the marketplace. If you have questions, please contact Joel Slackman at 202.626.8614 or joel.slackman@bcbsa.com.

Sincerely,

Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association