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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 – AHIP Comments

Submitted via 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 that CMS:

- 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; and
- Account for any satisfaction differences across metal levels.

We also offer the following 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 the length of the survey – as it contains 85 questions up from 76 in last year's survey – will discourage consumers from participating or completing the survey. As a comparison, it has been 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. Issuers have reported early results from the 2015 beta test indicating a much lower than expected response rate. This supports the need to significantly reduce the number of questions and reconsider the need for the new questions on items with a low incidence (e.g., after hours

care, formatted forms), as well as new questions that measure behaviors outside the control of the health plan (e.g., affordability questions).

In addition to reducing the number of questions in the About You section, which currently has 22 questions and is substantially longer than the current commercial or Medicare CAHPS questionnaire, we recommend reducing the length of the questionnaire by eliminating questions with low item response rates, since they will not provide statistically reliable results at the QHP issuer level. An additional way to reduce the length of the survey would be to move questions to the Marketplace Survey that are important for policy purposes but are not plan performance measures (e.g. Q56 and Q57).

Furthermore, 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. In general, tightly clustered plan measure scores, with small differences between cut points, are not good candidates for inclusion in health plan performance rating systems.

a. Existing CAHPS Health Plan Questions

Regarding, QHP Survey questions 12 and 13, it is unclear what the questions are measuring – use of language services or receipt of culturally and linguistically appropriate care. Moreover, the interpreter questions provide insufficient information regarding the success of the translation in meeting the member's needs, given that the member may use family, provider staff, and an actual service in the provider's office. Given the lack of clarity and the likelihood of low denominators, these questions appear to be of limited value and we recommend that they be removed to shorten the survey length. Alternatively, in order to better reflect Plan performance, these questions could be modified to address interpreter services within the Plan and not at the physician's office.

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, some of these 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, there is concern that survey responses to questions 20 and 25 may be speculative and are constructed in a way that relies on the patient to communicate that the action occurred. If CMS has conducted cognitive testing to validate the quality of the information respondents provide to these questions, it would helpful for plans to see the reports from this testing so that they can better understand how to interpret the results of these questions. Additionally, 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.

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.

- 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 tried to get information or help from customer service but did not succeed. Currently, such respondents are being screened out and only those affirming that they "got information or help" in question 42 proceed to answer the subsequent questions (43-45) 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. CMS should consider capturing the mode of contact used as well as the outcome of the call (e.g., spoke to a live representative, on hold too long, etc). This will help to more precisely define the appropriate respondent base for questions 44 and 45.

- 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 your health plan give or make available to you any forms to fill out?" CMS may also want to clarify whether this question is meant to include claims. Given that in the CAHPS 5.0 questionnaire there are separate questions about claims, we recommend that forms for claims be excluded from this question.

- Question 49 asks how often the forms an enrollee had to fill out were available in the language preferred by the enrollee. Given that the vast majority of respondents will be answering the surveys in English, with the exception of some smaller QHP issuers that target specific race/ethnic populations, these scores will be heavily skewed toward "Always," and as such, will not likely distinguish performance differences between QHP issuers. We recommend dropping this question, which will help shorten the questionnaire or only use this question if an individual usually receives forms in a language other than English.

- 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. Alternatively, if CMS perceives this information to be important from a public policy perspective, we recommend that it not be reported at the plan level for the small number of plans that may have enough respondents to have reliable scores.

- 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. In order to help health plans identify and concentrate on areas that need improvement, we recommend assessing the viability of including 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.

- Question 53 asks if enrollees would recommend their health plan to their friends and family. Given that this question is conceptually linked to, and immediately follows the Health Plan rating question (Q52), this question seems redundant and will not add much additional information. We recommend that CMS delete this question, which will help reduce the length of the questionnaire. If CMS retains this question, we recommend that the scale be changed to 0 "Not At All Likely" to 10 "Extremely Likely." This wording and scale allow for the calculation of a Net Promoter Score.

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 ask whether the respondent was uninsured just prior to signing up with their current health plan. Additionally, CMS may wish to consider moving this question to the beginning of the survey where the member is asked to provide the name of his/her health plan.

- Additionally, some of the "About You" question responses should be used to inform policy as some do not reflect a health plan's behavior. Other questions in this section, such as those relating to aspirin measures, should be removed since NCQA has documented methodological concerns with these measures and no longer reports these results.

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. 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.

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 as currently written.

For example, questions 54 and 55 ask whether a health plan has refused to pay for a service the enrollee's doctor said they needed and how often the enrollee has had to pay out-of-pocket for care they thought the plan would fully pay. These questions may be misinterpreted by many respondents. It appears that the questions are designed to assess whether members felt that their health plan refused to pay for a service that the doctor said they needed. Several reasons may lead a respondent to conclude that their plan did not pay for such a service: (1) it was not a covered benefit, (2) the health plan did not deem the service to be medically necessary, or (3) the service was covered but was subject to the plan's deductible, and the full cost of the service is the obligation of the respondent.

The third reason (i.e., subject to deductible) is likely to be the most common one experienced by respondents, and reflects that the respondent did not fully understand how their plan works. Furthermore, this issue is addressed more clearly in question 55 that asks "In the last 6 months, how often did you have to pay out of your own pocket for care that you thought your health plan would pay for?"

We recommend replacing Q54 and Q55 with questions that ask about the reasons why the health plan did not pay for a service that a member felt should have been paid by the health plan. For example:

> *In the last 6 months, did your health plan ever not pay for a service that your doctor said you needed because:*
> *(a) The health plan said the service was not covered under your plan (yes/no)*
> *(b) The health plan said the service was not medically necessary (yes/no)*

(c) The health plan said I had to pay the deductible first (yes/no)

If CMS decides to keep Q54 and Q55, we recommend moving them after Q56 and Q57. This change may help respondents focus their answers in Q54 and Q55 on the circumstances when they felt that their plan refused to pay for a covered service, without the confounding effects of services subject to the deductible. Similarly, the question wording could include a statement asking respondents not to include times when the health plan told them that they first had to pay the deductible.

Additionally, questions 56 and 57 seek to determine if the enrollee delayed or did not visit the doctor or fill a prescription due to cost. While these two questions cover an important policy issue regarding health plan benefit structures that help people to afford health care, these questions deal with issues that are beyond the control of health plans. First, QHP benefits structures are shaped by the actuarial coverage requirements of the different metal levels. Second, in many state-run marketplaces, the exact benefit designs to be offered at each metal level are specified; QHP issuers have none or little option to alter the coverage. Health plans cannot be held accountable for offering QHPs that provide coverage, such that some members feel that they cannot afford to get care.

Second, when choosing a health plan consumers balance the monthly premium that they want to pay, or can afford to pay, with the amount of out-of-pocket costs for care. Obviously, these personal trade-offs are not in the control of health plans.

Third, many consumers are compelled to buy health insurance to avoid the tax penalty associated with being uninsured. For many individuals, this results in them buying bronze or silver plans that have high deductibles (if ineligible for cost-sharing reductions). For many individuals the size of the deductible makes paying for health care services too expensive, or even unaffordable.

Finally, the higher deductible plans are designed to force individuals to confront the trade-offs between the cost of health care and their perceived value the health care. The underlying premise is that individuals with deductibles will, on average, make decisions not to seek more discretionary care, for example, seeking care for conditions that will get better on their own.

If CMS feels that the affordability of care under the QHP plans offered in the marketplaces is an important policy issue, these issues may be better addressed in the Marketplace survey. If CMS feels that it is vital to collect this information using the QHP Enrollee Satisfaction Survey, then CMS may want to consider reporting this information at an aggregated level, not at the level of an individual QHP issuer. For example, CMS may want to report these measures at the state level, or by metal level.

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. 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 unless these enrollees are excluded from the sample size due to the continuous enrollment criteria, 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 of the survey and use of the term health plan. First, in order to reflect the intent of the survey, the middle sentence of the Cover Letter's first paragraph should be changed to read: "This survey is part of a national ongoing effort to understand the experiences enrollees have with their health plans." Additionally, 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." If a respondent is not a current member of the plan then these respondents should be dropped. Including them, and asking them to think back to their experiences with the prior plan is inconsistent with the standard CAHPS protocol. Furthermore, many respondents will be confused or even forget the instructions in the cover letter, since the CAHPS questions repeatedly ask about the timeframe, "In the last 6 months." In addition, many individuals will not be answering this survey until April

or May. Including respondents who are not currently enrolled in the plan will mean that their responses will be based on experiences 4 or 5 months after leaving the plan.

Third, if CMS chooses to include respondents not currently enrolled in the plan, there needs to be additional clarification to minimize confusion. For example, while some consumer may switch insurers, others may change QHPs within the same issuer. Clarification with respect to issuer will help survey respondents more accurately identify how they would like to respond.

Finally, the Cover Letter indicates that the information provided will only be shared with authorized persons. We recommend that additional information be provided indicating what entity (e.g., survey vendor) is authorized to see the information.

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. We look forward to continuing to work with you as you refine the enrollee experience survey. Please feel free to contact me if you have any questions.

Sincerely,

Carmella Bocchino
Executive Vice President