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Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

Submitted via: OIRA_submission@omb.eop.gov

**SUBJECT: (CMS-10488/OMB control number: 0938–1221) Consumer Experience Survey Data Collection**

To CMS Desk Officer:

The Blue Cross Blue Shield Association – a national federation of 36 independent, community-based and locally-operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 106 million members, or one-in-three Americans – appreciates the opportunity to comment on the notice concerning revision of a currently approved information collection, "Consumer Experience Survey Data Collection," as published in the *Federal Register* on July 24, 2015 (80 *Fed. Reg.* 44131).

Section 1311(c)(4) of the Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to develop an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through an Exchange. It also requires public display of enrollee satisfaction information by the Exchange to allow individuals to easily compare enrollee satisfaction levels between comparable plans.

Our comments focus on four questions related to enrollees' experiences with the out-of-pocket costs associated with their plan (Q54-Q57), which were excluded from the 2015 beta test version of the QHP Enrollee Survey but added to the 2016 QHP Enrollee Survey. We believe questions such as these have the potential to help consumers choose among competing health plans, and provide actionable information that the QHPs can use to improve performance – CMS objectives that BCBSA strongly supports.

However, in the context of CMS's statistical methods for the survey, we have significant concern about the utility of these questions: because the sampling/reporting unit is the product type, not stratified by metal level, aggregate survey responses will be difficult to interpret because each sampling unit could include varying numbers of QHP members who specifically bought products that pay fewer costs.

**Therefore, BCBSA recommends either deleting these questions from the 2016 Survey, or withholding clearance until CMS provides a statistical methodology to adjust results when making comparisons across sampling units.** In fact, the statistical methodology may also have implications for global health plan ratings (Q52) because products with more members enrolled in higher cost-sharing designs are likely to have lower ratings. This impact of cost sensitive members' global rating of their health plan can mislead consumers when choosing a plan.[1]

In addition, we are concerned the wording of the questions themselves may yield biased responses due to ambiguities in how enrollees perceive their coverage. **Therefore, BCBSA recommends that if the 2016 Survey includes these questions, they be clarified to minimize the chances of biased responses.**

These concerns and recommendations are detailed below.

**Statistical Methods**

**Issue**. The 2016 QHP Enrollee Survey includes the following four questions that were not in the 2015 beta test version:

- Q54. In the last 6 months, how often did your health plan not pay for care that your doctor said you needed?
- Q55. 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?
- Q56. In the last 6 months, how often did you delay or not visit a doctor because you were worried about the cost?
- Q57. In the last 6 months, how often did you delay or not fill a prescription because you were worried about the cost?

Questions such as these – if revised as recommended in the next section – potentially provide valuable insight into consumers' choices among competing health plans and, especially when combined with various demographic and administrative data such as, age, race, and eligibility for the Advance Premium Tax Credit (APTC), provide actionable information that QHPs could use to improve performance.

However, as explained in PRA *Supporting Statement—Part A*, "CMS has established the sampling/reporting unit at the product type (i.e., Exclusive Provider Organization [EPO], Health

[1] Pacific Business Group on Health, "The Rating Game: A Closer Look at How Cost Sharing Influences Consumer Ratings of Health Plans." (2011).

Maintenance Organization [HMO], Preferred Provider Organization [PPO], Point of Service [POS]) offered by a QHP issuer through the Marketplace in a particular state. For example, XYZ issuer's HMOs offered through the Marketplace in Florida would be considered a single sampling unit. Depending on the way a QHP issuer packages its plan offerings, the sampling unit might include anywhere from a single QHP to many QHPs spanning all categories of coverage (i.e., bronze, silver, gold, platinum, catastrophic)."

The problem is the inverse relationship between a health plan's level of coverage and the experience of its members paying more than expected out of pocket, or delaying or eschewing care because of worries about cost. For example, research from the Pacific Business Group on Health (PBGH) shows that consumers who are more sensitive to costs tend to give their health plans lower quality ratings – presumably, consumers attracted by relatively low premiums into choosing bronze QHPs will be more sensitive to costs than consumers choosing higher metal levels. BCBSA's own survey research into Plan members' experience complements PBGH's research: how members perceive the overall value of benefits is largely a function of how much they have to pay out-of-pocket for care under those benefits (e.g., those having expenses less than $1,000 per year are considerably more likely to be satisfied with the value of their coverage than those with expenses of $4,000 or more).

Thus, responses to the four questions about cost could conflate what may be real differences among QHP issuers and their products with differences in experience that are due to varying metal levels (i.e., people who buy QHP products that are relatively cheap because those QHPs have higher cost-sharing will report different experiences for reasons that have little to do with real QHP differences). If members' experience paying out-of-pocket or delaying care is better or worse for one QHP issuer's PPO than for another's, the difference may largely be an artifact of the way a QHP issuer packages its plan offerings.

**Recommendation**. Before OMB clears the QHP Enrollee Survey for national implementation beginning in 2016, we recommend CMS address the above issue by either:

- Deleting Questions 54-57 from the 2016 QHP Enrollee Survey. As indicated in *Supporting Statement—Part A,* CMS is exploring collecting data at the metal level in the future, and CMS will revise this Information Collection Request if it makes such a change; or

- Providing details of a statistical methodology for adjusting the display or use in the Quality Rating System of QHP product type results to account for the effects of varying metal levels in the sample units. (This adjustment is needed not only for the questions related to enrollees' experience with cost, but also for proper interpretation of the question on enrollees' global rating of their health plan. As BCBSA's consumer survey research shows, Plan members' likelihood of recommending their insurance plan to family and friends – a type of global rating measure – varies significantly by out-of-pocket expenses: e.g., those spending less than $1,000 a year are considerably more likely to recommend their plan than those spending $4,000 or more.)

**Question Wording**

**Issue**. Respondents may report their health plan did not pay for care their doctor said was needed, or they unexpectedly paid for care out of pocket because their perceptions of what should be covered do not match up with the benefit design. For example, a plan may not pay for care one's doctor said was needed because the plan is an EPO and the doctor is out-of-network. Or a plan may not pay for care, or one may have to pay out of pocket, because the service is counted against the enrollee's deductible: from an enrollee's perspective, services that go against the deductible may be misperceived as care that the health plan should have covered. These misperceptions of coverage would lead to results that are difficult to interpret.

**Recommendation**. If questions 54 and 55 are included – assuming CMS provides the recommended statistical methodology for making meaningful comparison across sampling units – we recommend revising the wording to clarify that services may not have been covered because of the benefit design:

- Q54. In the last 6 months, how often did your health plan not pay for care that your doctor said you needed (excluding the deductible or any form of cost sharing for the visit itself, or a doctor who was not eligible to provide care).

- Q55. In the last 6 months, how often did you have to pay out-of-pocket for care that you thought your health plan would pay for (excluding the deductible or any form of cost-sharing for the visit itself)?

In addition, we recommend giving consideration to eliminating Q54 because it is similar enough to Q55 to be redundant, and its negative tone may induce respondents to recall adverse interactions with plans.

Thank you for consideration of our comments. If you have questions please contact me at 202.626.8614 or joel.slackman@bcbsa.com.

Sincerely,

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Office of Policy and Representation