Summary of Public Comments on the Healthy Indiana Program (HIP) 2.0 Federal Customer Satisfaction Survey Instrument Testing

Date: April 25, 2016

INTRODUCTION

On March 29, 2016 the Centers for Medicare & Medicaid Services (CMS) announced an opportunity for the public to comment on the information collection concerning CMS' Healthy Indiana Program (HIP) 2.0 Beneficiaries Survey. This solicitation for public comment occurred simultaneously during the testing and development phase of the survey instruments. Public comments were accepted through April 8, 2016 and will be utilized to further inform the continued development of the federal beneficiary survey instruments for HIP 2.0. In total we received one public comment from the National Health Law Program (NHELP).

The purpose of this document is to provide a summary of this important public comment and our responses to those comments. Our responses to the public comments are outlined below and organized in the following order: General Comments on the Draft Beneficiary Surveys, Health Coverage Cost and Payment Options Survey Section, HIP 2.0 Beneficiary Survey: Disenrollees & Lockouts, HIP 2.0: Enrollees, and HIP 2.0: New Enrollees.

General Comments on the Draft Beneficiary Surveys

Comment: Below we provide comments on each of the four draft surveys included in this public comment request. As a general recommendation, we would like to reinforce the importance of ensuring questions directed at a beneficiary audience are drafted at a low literacy level. Many beneficiaries read at low literacy levels or have limited proficiency in English (LEP) and may have trouble understanding complex questions. We suggest having literacy experts review the final questions and ensure they do not exceed a 6th grade reading level (or a lower literacy level as may be appropriate for the relevant population).

Response: Prior to submitting the beneficiary survey instruments to CMS and OMB for approval the surveys were administered through an English readability program to assess the reading grade level. All instruments reported an average grade reading level of 5. The average grade reading level was calculated based on the following readability formulas: Flesh-Kincaid Grade Level, Gunning-Fog Score, Coleman-Liau Index, SMOG Index, and Automated Readability Index.

Comment: Further, the survey administrator should translate the survey into the top non-English languages in the beneficiary population and ensure sufficient sample size of LEP beneficiaries to obtain validated results. LEP individuals may experience access to healthcare differently than English speakers, particularly if language barriers impede access to care. Thus, the survey must include participation of LEP individuals from all language groups (that is, administering the survey in Spanish would be insufficient if HIP 2.0 also enrolls a significant number of other non-English language speakers). If LEP

individuals cannot be identified in advance (to be sent an in-language survey), we recommend that the survey scripts/introductions include tag lines in the top 15 common languages in Indiana with clear instructions how an LEP individual can get assistance responding to the survey. The survey sample should not implicitly omit LEP individuals simply because they are unable to complete a survey in English.

Response: LEP individuals are an important but relatively small proportion of the total population of HIP beneficiaries in Indiana. As of 2012, Hispanics represented 6% of total population in Indiana. An estimated 3.3% of the total HIP enrollee population in 2012 was Hispanic, and one-third of the Hispanic population in Indiana was estimated to speak English less than very well (American Community Survey, 2012). Due to time and cost considerations for the evaluation, we chose to focus our efforts on English and Spanish speakers only, noting that a very small proportion of Hispanic HIP beneficiaries are anticipated to be LEP (about 1% of the total HIP enrollee population). Nevertheless we are prepared to accommodate Spanish language questionnaires and /or interviewer for up to 10% of completes. Proportions of LEP among other racial/ethnic groups are likely not sizeable due to the lower representation of those groups in Indiana compared to Hispanics.

Health Coverage Cost and Payment Options Survey Section

Comment: The questions in to this draft survey about preferences for health plan cost structure are unclear and likely confusing for respondents. First, the script should clearly define all relevant terms and explain how they are connected. We are not confident that all participants will know what copays are, as the script does not define the term or distinguish them from monthly contributions. We also suggest that "premiums" is a more commonly used and broadly understood term than "contributions" with regard to monthly payments for healthcare coverage. Finally the script should also make clear that the amounts of premiums and copays are related in health plans, with higher premiums corresponding with lower copayments.

Response: The definition for copays has been added to the narrative in the beginning of this survey section. We opted to not utilize the term 'premium' to be consistent with the beneficiary educational materials and marketing disseminated in the state of Indiana. Furthermore, during the survey testing period all testing participants expressed a clear understanding of the use of 'monthly or annual contributions'. We want to ensure that survey respondents (HIP 2.0 enrollees and disenrollees) understood what health plan components we would like them to think about in the health plan scenarios and we determined that maintaining the consistent use of 'contributions' throughout the entire survey instrument would increase clarity for respondents.

Comment: More specifically, the inverse relationship between premiums and copays is implicit in the structure of Question 1, as follows:

"1. If you could choose, how would you like to pay for your health care services?
a. I would like to pay copays at my health care visits

b. I would like to make monthly or annual contributions
c. I would like to make a combination of monthly or annual contributions and copays
d. It does not matter to me"

Without a clear explanation, who would ever say they prefer to pay copayments AND monthly contributions? For those who understand the inverse connection, we also think question 1 is likely to have a response bias due to the compromise effect.3 Option C represents middle ground between A and B. If the goal is to weigh preference for premiums against copays, it would be better to have only two options and not include the middle ground response. We also suggest that question 1 should substitute the word "rather" to make clear that the question is about weighing different options. No one "likes" to pay copays or premiums. 3 The compromise effect posits that survey respondents gravitate toward the middle ground when offered three options, regardless of whatever the options may be.

Response: We agree and the answer option regarding the combination of both contributions and copays has been eliminated.

Comment: The hypothetical comparison applicable to questions 2 through 5 apparently attempts to measure if individuals would be willing to pay a little extra in copays in exchange for a shorter lockout. But the scenario makes it impossible to meaningfully choose between health plans if there are no relative costs attached. The answers would be completely different if you weight a $25 monthly contribution versus $4 copays, as opposed to a $4 monthly contribution and $4 copays. (This same lack of specificity also applies to Question 1). Without any specific details, it becomes nearly impossible to draw any valid or actionable conclusions from the answers collected (whatever those answers may be.)

A more useful approach would be to test the same questions using different dollar amounts for monthly contributions and premiums, to gauge quantitatively how respondents value the risk of missing a payment. Also, Plan B in the scenario reads like a "reasonable compromise" as well ("some" copays), and we believe is more likely to receive a positive response simply due to the language in the scenario.

Response: During the survey development process, we developed iterations of questions using the same approach proposed in the comment above. After soliciting feedback from several survey experts and through cognitive testing/debriefing, we opted to keep the questions as simple and few as possible. We determined that the exercise of comparing two hypothetical plans was challenging enough for participants; having to consider dollar amounts on top of weighing contributions versus copays likely would have been too taxing.

Comment: Finally, question 6 is fatally flawed to the point where we question its inclusion in the survey. What respondent would say they do not want choice? We recommend eliminating or completely restructuring this question. Perhaps it could be designed as a ranking list to identify what people prioritize in choosing a health care plan (network, cost structure, managed care company, etc.)

Response: During the survey testing we found that not all respondents care about having a choice. Given the findings from the survey testing, we have decided to keep this survey question. The ranking

list question option could serve as an alternative but does introduce a different question structure that we do not currently include throughout the survey. We will retain the original question for now and consider the proposed question structure in future survey development efforts.

Healthy Indiana Plan 2.0 Beneficiary Survey: Disenrollees & Lockouts

Comment: Question 1 can easily be misread as a choice between "Healthy Indiana Plan" and "HIP 2.0." This potential misreading could be easily corrected as follows:

"Are you currently enrolled in the 'Healthy Indiana Plan 2.0' or (***also called*** 'HIP 2.0')?"

Response: Yes, we made the same change during the testing period. This has been updated to include "2.0."

Comment: Question 10 is a critical question in light of the flawed Lewin evaluation of NEMT and access to care that evaluated whether individuals have missed appointments due to lack of transportation. (For example, the Lewin analysis would not capture how the NEMT waiver impacts the subset of enrollees do not bother making an appointment because they know they cannot get transportation.) Asking about unmet need, rather than missed appointments, does capture this group. We would recommend adding a row to specifically inquire about access to specialists, who are often harder to access because they require longer trips.

Response – Now Question 12: During the survey instrument testing we assessed what participants thought of when answering this question. Thinking about the care received from their "doctor," a few participants included specialists in their notion of "doctor." Also, this question was adapted from the Behavioral Risk Factor Surveillance System (BRFSS) survey; the specialists that BRFSS specifically includes in the question are dental.

Comment: Question 11: We support this question focusing on paperwork, as prior evidence from HIP evaluations showed that incomplete renewal forms was one of the leading causes for disenrollment. It may be important to include an option here or in Question 13 to describe someone whose income went up and was determined ineligible. It would be useful to add questions to test individual's awareness of the 6- month lockout and when they might become eligible again. Possible follow-ups for Question 11 could include:

If YES (to options A or B): ***"Did you know while you were in HIP 2.0 that you would not be able to reenroll for six months if: A. You did not make payments on time? (Yes, No, Not sure) B. You did not fill out your renewal forms on time? (Yes, No, Not sure)"***

"Are you currently barred from enrolling in HIP 2.0? (Yes, No, Not sure)

"Do you know how long you have to wait, if at all, before you may reapply? (Yes, No, Not sure)"

Response: We agree and have added a survey question assessing awareness of the length of the lockout period if respondents report understanding of their lockout policy. That survey question addition can be seen in question 27 in the HIP 2.0 Disenrollee and Lockout survey. We did not add in a question assessing awareness of the consequences related to incomplete renewal forms as that policy does not apply in HIP 2.0.

Comment: In Question 13, it would be informative to leave a blank for an individual to fill in an answer in the "other" box.

Response – Now Question 14: During the survey testing participants pointed out that "Other" did not apply here. We have eliminated that answer option. Additionally, to minimize burden and reduce costs we are not including open-ended survey questions in these instruments.

Comment: Question 14: Previous data from the HIP 1.0 evaluations indicated that roughly one in four HIP enrollees did not know what a POWER account was. Such data has important implications for interpreting results on how the HIP healthy behavior incentives work (since they are predicated on awareness of the POWER account). We appreciate and support that this survey appears to ask everyone to answer the more detailed questions on how POWER account works. Even if someone thinks he does not have a POWER account or is not sure, he may know other details about how his coverage works. However, the wording of subsequent questions may be awkward for individuals who report in question 14 that they do not have a POWER account (or are unsure). Specifically, questions referring to "your" power account would seem strange to someone who previously answered they do not have one (even if they actually do have one). We recommend rewording the subsequent questions in this section so they are not in second person. We also suggest adding a "not sure" option to this question, as follows:

> "14. Do you have a POWER account? POWER accounts are special savings accounts called Personal Wellness and Responsibility Accounts. (Yes, No, ***Not sure***)"

Response – Now Question 16: During the survey testing respondents expressed confusion around understanding their POWER accounts. The proposed changes align with our anticipated changes to the survey questions relating to POWER accounts. The answer option "not sure" has been added to this particular survey question and all questions referring to a participant's POWER account have been changed to a general reference.

Comment: Questions 17 & 18: We support these questions about affordability of monthly contributions. However, as currently structured, both this and the Enrollee survey (see below, Section 3) only ask about financial burden concerns related to monthly contributions. We strongly recommend adding extra questions on beneficiary concerns about financial burden concerns directed specifically at HIP members who have to pay copays. Those questions could parallel the structure of Questions 17 &18 and could be asked in the section for HIP Basic members (between questions 39 & 40, for example).

Response – Now Question 19 & 20: We agree with the proposed additions and have added some survey questions. Respondents indicating that they do not make contributions will be asked questions relating

to the affordability and level of worry in paying their copays (financial burden concerns). The questions added mirror questions asked of individuals who are paying contributions.

Comment: Question 20: We recommend asking specifically about awareness of the six month lockout here, if not already included elsewhere in this survey. Evidence that enrollees are actually aware of the lockout threat is a necessary precondition to evaluate the state's claim that the lockout will reduce nonpayment of premiums.

Response – Now Question 26: We agree and have added a survey questions assessing awareness of the length of the lockout period if respondents report understanding of their lockout policy. That survey question addition can be seen in questions 27 in the HIP 2.0 Disenrollee and Lockout survey.

Comment: Question 23: This question appears to be testing individuals' knowledge of how the POWER account works. However, statements B, C and D (on whether the POWER account helps individuals get or pay for health care services or helps them feel comfortable paying) are vague and leading questions. Most enrollees will likely agree (since their POWER account card is basically their insurance card, and it does pay the costs). However, any health plan or state Medicaid program would help covered individuals pay for services they use, so these statements do not test anything unique to the POWER account structure. A more specific, appropriate statement would be to ask if the POWER account helps individuals understand the cost of their health services, which is a stated purpose of the POWER account. We recommend deleting statements B, C & D, and adding a new B as follows:

"B. ~~My POWER account helped me get the health care services I needed.~~ ***My POWER account helped me understand the cost of my health services."***

~~"C. My POWER account helped me pay for my health care services."~~

~~"D. My POWER account made me feel comfortable about paying for my health care services."~~

Response –Now Question 31: The proposed changes to the revisions of this survey question were considered. Most all of the recommendations provided were accepted largely due to the findings from the survey testing. The majority of respondents were familiar with POWER accounts in general, but their understanding of the POWER accounts varied. During the instrument debriefing interviews it was not clear that all testing respondents fully understood how to use their POWER accounts (or that their POWER accounts were associated with their debit cards). Given the results, we have opted to keep some of the answer options. We also added in (agree/disagree/not sure) "HIP 2.0 monthly or annual contribution(s) go to a POWER account" to capture POWER account beneficiary understanding and "POWER accounts help people understand the cost of their health care services."

Comment: Questions 24-26: We support detailed questions on POWER account rollover and preventive care incentives. We also note that earlier evaluations of HIP routinely excluded individuals who did not know they had a POWER account from the reported responses about how HIP healthy behavior incentives work. We support that this survey appears to include everyone in the pool questions on

POWER accounts and behavior incentives. However, as mentioned above, the wording may seem strange for individuals who reported in question 14 that they do not have a POWER account or are unsure. We recommend rewording these questions so they avoid the second person. We also recommend adding a follow up to test respondents' understanding of what counts as preventive care for them, as follows:

"25. Is the cost of preventive services ~~deducted~~ ***paid*** from ~~your~~ ***the*** POWER account?"

Follow-up: "Do you know what care qualifies as preventive care for yourself? For your children?"

"26. If ~~you~~ ***someone*** gets **all or some** of ~~your~~ ***his*** recommended preventive services, will some of the remaining money in ~~your~~ ***his*** POWER account get rolled over into next year?" .

Response –Now Question 32 – 34: The proposed changes have been accepted. These recommendations mirrored the revisions we had identified after the debriefing interviews concluded. However, we chose not to use the proposed survey question ("Do you know what care qualifies as preventive care for yourself? For your children?") given that preventive services vary by age and gender groups. Instead we included a definition of preventive services. During the debriefing interviews, respondents indicated that they understood the definition; the examples we provided were what they usually thought of as preventive services.

Comment: Question 28: We recommend adding a reference to prescription drugs to ensure this question captures the broadest scope of HIP 2.0 services, as follows:

"In the last 6 months, did you go to a doctor, nurse, or any other health professional or **use a prescription medication**? (Yes/No/Not sure.)"

Response – Now Question 36: We agree. That addition has been included.

Comment: Question 29: We support the inclusion of a definition for copays in this question, but the question itself may not be appropriate for HIP disenrollees. An uninsured respondent who went to a doctor after being disenrolled (and had to self-pay) would not be asked for a copay, but would be asked to pay the whole bill. The wording in question 29 should address this possibility, such as adding a response option: "***C. No, I was asked to pay the whole bill."***

Response –Now Question 37: We agree and have changed the language to assess the time period "since they left HIP 2.0." In analysis we will look at the disenrollees and HIP Plus lockouts who have indicated whether they have health insurance coverage at this time (see question 6 in the HIP 2.0 Disenrollee and Lockout survey).

Comment: Questions 32, 44, and 46: Individuals who respond "somewhat satisfied" with HIP 2.0 or neutral should also have the option to offer suggestions on how to improve HIP and identify what makes them only "somewhat" satisfied or neutral.

Question 34: Respondents may not be aware they have HIP Basic coverage. We recommend adding a "not sure" option to this question.

Response: The answer option of "Not sure/Don't know" has been added.

Questions 36-37: We recommend adding a box to give respondents the option to explain an "other reason" for liking or not liking HIP Basic.

Response – Now Questions 40, 52, and 54: While we understand the importance of following up with those reporting 'somewhat satisfied' or 'neutral' we have decided not to include open ended survey questions in these instruments due to length and cost. Qualitative analyses will capture reasons for satisfaction/dissatisfaction.

Healthy Indiana Plan 2.0 Beneficiary Survey: Enrollees

Comment: This survey is generally well-structured. We particularly support the questions on NEMT and access to care, with some slight modifications. We also strongly support the specific questions meant to measure respondent's knowledge of the ER copay protocols. We recommend adding questions to test whether current enrollees are aware of the potential to be locked out if they fail to pay or if they fail to return their renewal forms on time.

Response: We have added a survey question to assess the awareness of the length of the lockout period if respondents report understanding of their lockout policy. That survey question addition can be seen in questions 33 in the HIP 2.0 Enrollee survey. We did not add in a question assessing awareness of the consequences related to incomplete renewal forms as that policy does not apply in HIP 2.0.

Comment: Question 1 can easily be misread as a choice between "Healthy Indiana Plan" and "HIP 2.0." This potential misreading could be easily corrected as follows:

"1. Are you currently enrolled in the 'Healthy Indiana Plan 2.0,' or (***also called*** 'HIP 2.0')?"

Response: Yes, we made the same change during the testing period. This has been updated to include "2.0."

Comment: Question 2: We are concerned that respondents may not understand the phrase "benefits package" and suggest using "plan" instead. We also suggest adding a follow-up question prompting the individual to report whether they are in HIP Plus or HIP Basic (or state plan coverage?).

Response – Now Question 3: During the survey testing we assessed if participants understood the use of the term "benefits package." Testing participants reported a clear understanding.

Comment: Question 3: We are concerned that respondents may not understand the phrase "benefits package." The questions can be easily simplified using the phrase "plan" instead of "package", as follows:

"For the next question, please think about your HIP 2.0 benefit ***plan*** ~~package. For each of the following items, please indicate whether they~~ Which of the following items are part of your HIP 2.0 benefit ***plan*** ~~package~~? Copays are payments you make at the time you visit your doctor's office, go to the hospital or get prescription drugs."

"My HIP 2.0 benefit ~~package~~ plan…"

Response – Now Question 4: During the survey testing we assessed if participants understood the use of the term "benefits package." Testing participants reported a clear understanding. The strategic use of 'health plan' was discussed during the early phases of the survey development process. The use of 'health plan' to reference only the managed care entities participating in HIP (e.g., Anthem, MDwise, MHS, etc.) was deemed appropriate by an expert review of the HIP informational materials (online materials) available to the public.

Comment: Question 5: This question is confusing and suggests a false distinction between Medicaid and HIP 2.0. Medicaid has not been mentioned at all in this survey, and is not necessary here. We recommend simplifying the question as follows:

~~"Sometimes Medicaid or a benefits package provides transportation or covers the costs of transportation to and from health care visits. This could include mileage or taxi reimbursement or having a number to call your health plan to arrange transportation for you.~~

~~"Does Medicaid or your HIP 2.0 benefits package provide transportation or cover any of the costs of your transportation?"~~

Sometimes people need help getting to and from their healthcare visits.

A. Does your benefit plan provide transportation to and from healthcare visits (not including an ambulance)?
B. Does it cover any of the cost of transportation to and from health care visits? (Note: this could include having a number to call to arrange your transportation or paying for your taxi, bus fare or mileage in a car.)"

Response – Now Question 7: "Medicaid" has been deleted. During the survey testing participants reported that they understood the question as presented. When tested about "paying for" and "getting" transportation together in one question, participants reported understanding the question and were not confused.

Comment: Question 6: Eliminate the reference to Medicaid (see above, question 5)

Response – Now Question 8: The elimination of the word 'Medicaid' from this question has been made and will help maintain simplicity and consistency among the surveys.

Comment: Question 9: Some individuals may have missed multiple doctor visits due to a lack of transportation access. It would be useful to quantify the number of times someone did not get care for each listed category.

Response – Now Question 12: The recall period in this question is the last 6 months. We feel that this approach accurately captures a cost barrier to care, and that asking respondents to quantify the times they needed care and the times they experienced a cost barrier would be too burdensome. The structure of this question was adapted from BRFSS survey questions.

Comment: Questions 17-19: Question 17 is subjective and does not clearly distinguish between what the respondent may think was an emergency and what the ER attending physician may have decided was an emergency. That distinction is critical to ensure the correct protocol was followed. Namely, the survey should measure whether ER providers are fulfilling the screening, notice and referral requirements before charging any copays. We also note that all of the potential answers to Question 18 are covered in Question 19, but Question 19 also includes the possible response that a third party paid the copay. In fact, the current question structure would make it impossible to find out if a third party ever paid the copay. In such a case, the respondent would correctly answer "No" to question 18 – "Did you pay the copay?" – and then be prompted to go to the following section on POWER accounts without ever answering question 19 to indicate a third party paid it. For these reasons, we recommend deleting question 17, rewording questions 18 and 19, and adding a follow-up question between 18 and 19, as follows:

~~"17. The last time you went to the emergency room, was it for an emergency?"~~

"18. ~~Did you~~ **The last time you went to the emergency room, were you asked** to pay a copay?" (Yes, no – GO TO POWER ACCOUNTS, not sure – GO TO POWER ACCOUNTS SECTION) "

Follow up: ***"18A. If yes, were you told your condition was not an emergency? (Yes, No, Not sure) If yes, were you told about another available provider where you could get care with lower or no copay?" (Yes, no, not sure)"***

"19. How was that copay paid, if at all?..."

Response: The original question 17 has been removed. During the survey testing we examined the skip logic in this survey section and found that testing participants did experience some confusion. After reviewing the testing results and the recommendations in this comment we decided that individuals who report paying a copay in the emergency room would mean they did use the emergency room for seeking treatment of a non-emergency condition..

While we recognize the importance of measuring if ER *providers* are fulfilling the appropriate emergency condition screening, notice, and referral requirements before charging any copays, these survey instruments are intended to focus on *beneficiary* understanding, experience, and satisfaction with HIP 2.0.

Comment: Question 20: We support this question on why individuals avoid the ER, but suggest adding a box to write in "other" reasons for not going, and adding an option about delaying care, as follows:

"D. Waited to see if I would get better on my own"

Response – Now Question 22: The proposed answer option 'waited to see if I would get better on my own' has been added.

Comment: Question 21: Data from the HIP 1.0 evaluations indicated that roughly one in four enrollees did not even know what a POWER account was. Such data has important implications for interpreting results on how the HIP healthy behavior incentives work (since they are predicated on awareness of the POWER account). We appreciate and support that this survey appears to ask everyone to answer the more detailed questions on how POWER account works. Even if someone thinks he does not have a POWER account or is not sure, he may know other details about how his coverage works. However, the wording of subsequent questions may seem awkward for individuals who report in question 21 that they do not have a POWER account (or are unsure). Specifically, questions referring to "your" power account would seem strange to someone who previously answered they do not have one (even if they actually do have one). We recommend rewording the subsequent questions in this section so they are not in second person. We also suggest adding a "not sure" option to this question, as follows:

55. "Do you have a POWER account? POWER accounts are special savings accounts called Personal Wellness and Responsibility Accounts. (Yes, No, ***Not sure***)"

Response – Now Question 23: During the survey testing respondents expressed confusion around understanding their POWER accounts. The answer option "not sure" has been added to this survey question.

Comment: Questions 22 - 27: Question 22 appears to incorrectly direct individuals who do not contribute monthly contributions to a set of questions intended for individuals who are in HIP Plus (which requires contributions). The directions in option D should direct individuals to Question 27, not Question 24. We also note that the questions on affordability concerns (24 & 25) should not be limited to asking about monthly contributions. Individuals in HIP Basic should also answer questions on their financial burden concerns relating to copayments (slotted between questions 27 and 28). .

Response – Now Question 24 - 29: This typo has been corrected. Respondents who indicate they do not make contributions will be asked questions about the affordability and level of worry in paying their copays (financial burden concerns). The new questions mirror questions asked of individuals who are paying contributions.

Comment: Question 30: This question appears to be testing individuals' knowledge of how the POWER account works. However, statements B, C and D (on whether the POWER account helps individuals get and pay for health care services or helps them feel comfortable paying) are vague and leading questions. Most enrollees will likely agree (since their POWER account card is basically their insurance card, and it

does pay the costs). However, any health plan or state Medicaid program would help covered individuals pay for services they use, so these statements do not test anything unique to the POWER account structure. A more specific, appropriate statement would be to ask if the POWER account helps individuals understand the cost of their health services, which is a stated purpose of the POWER account. We recommend deleting statements B, C and D, and adding a new B as follows:

"B. ~~My POWER account helps me get the health care services I needed.~~ ***My POWER account helps me understand the cost of my health services***."

~~"C. My POWER account helps me pay for my health care services."~~

~~"D. My POWER account makes me feel comfortable about paying for my health care services."~~

Response – Now Question 37: In the testing period, the majority of respondents were familiar with POWER accounts in general but their understanding of their own POWER accounts varied. We have opted to keep some of the answer options, and added in (agree/disagree/not sure) "HIP 2.0 monthly or annual contribution(s) go to a POWER account" to capture POWER account beneficiary understanding and "POWER accounts help people understand the cost of their health care services."

Comment: Question 31 - 33: We support detailed questions on POWER account rollover and preventive care incentives. We also note that earlier evaluations of HIP 1.0 routinely excluded individuals who did not know they had a POWER account from the reported responses about how HIP healthy behavior incentives work. We support that this survey appears to ask all respondents to answer all questions on POWER accounts and healthy behavior incentives. However, as mentioned in the prior section, the wording of these questions may seem strange for individuals who reported in question 21 that they do not have a POWER account or are unsure. We recommend rewording these questions so they avoid the second person. We also recommend adding a follow up to test respondents understanding of what counts as preventive care for them, as follows:

"32. Is the cost of preventive services ~~deducted~~ ***paid*** from ~~your~~ ***the*** POWER account?"

Follow-up: "Do you know what care qualifies as preventive care for yourself? For your children?"

"33. If someone gets all or some of your his recommended preventive services, will some of the remaining money in your his POWER account get rolled over into next year?"

Response – Now Question 38-40: The proposed changes have been made. Given that preventive services vary for specific age and gender groups we did not pursue this approach. We did include a definition of preventive services. During the debriefing interviews, respondents indicated that they understood the definition, and the examples we provided were what they usually thought of when thinking about preventive services.

Comment: Question 35: As currently structured, an enrollee who failed to get any needed care in the last six months due to the cost would answer "No" to question 35 and then would be directed to skip

questions 39 & 40 that ask about unmet care needs due to the cost. The answer options for "no" and "not sure" in this question should direct individuals to question 39 (on not getting needed care due to cost), instead of question 41 (on enrollee satisfaction). Another possible solution would be to slot questions 39 & 40 before 35 so that everyone answered them, not just the universe of individuals who have received some kind of care in the last six months. Also, we recommend adding a reference to prescription drugs to Question 35 to ensure it captures the broadest scope of HIP 2.0 services, as follows:

"In the last 6 months, did you go to a doctor, nurse, or any other health professional or **use a prescription medication**?"

"A. Yes."

"B. No . GO TO QUESTION ~~41~~ 39."

"C. Not sure/Don't know . GO TO QUESTION~~-41~~ 39."

Response – Now Question 36: This typo has been fixed. "Prescription drugs" has been added.

Comment: Question 36: We support the inclusion of an explanation for what copays are. The universe for this question may include both HIP Basic and HIP Plus individuals who used health services (e.g., HIP Plus who paid ER copays).

Response – Now Question 43: The question universe has been updated to include HIP Plus.

Comment: Questions 39 - 40: As currently structured, only individuals who have received some care in the last six months would answer this question (see above on Question 35). Individuals who avoided all care in the last six months due to cost (and so did not visit any health professional) would skip these important questions. Either these two questions should precede Question 35 or Question 35 should be altered to direct respondents to these two questions instead of the next section.

Response – Now Question 47-48: The skip logic typo has been fixed.

Comment: Question 41: Individuals who respond "somewhat satisfied" with HIP 2.0 or neutral should also have the option to offer suggestions on how to improve HIP or identify what makes them only "somewhat" satisfied.

Response – Now Question 48: While we understand the importance of following up with those reporting 'somewhat satisfied' or 'neutral' we are not including open ended survey questions in these instruments due to length and cost. The qualitative analyses will attempt to capture reasons/suggestions.

Healthy Indiana Plan 2.0 Beneficiary Survey: New Enrollees

NHeLP provided comments and recommendations on seven survey questions in this survey instrument. In response to this public comment, we have made revisions on four survey questions. The original comments and our responses to each comment is outlined below.

Comment: We support the idea of asking new enrollees separate questions specifically about the enrollment process. However, we would like to see this survey also include questions to test new enrollees' understandings of the cost sharing structure and use of preventive services. New enrollees should have already been informed of these elements during enrollment, and there is no reason not to include them in the pool of respondents. We do not specify these additional questions in our recommendations below, but they should follow the questions on these topics in the regular enrollee survey.

Response: We excluded these questions for a few reasons, namely budget constraints, respondent burden, and recall period. The primary focus of the new enrollee survey is to obtain beneficiary understanding, experience, and satisfaction with regard to the enrollment process. Increasing the length of the new enrollee survey would increase the burden on respondents. While we understand the importance of both the cost sharing structure and the use of preventive services, it is important that several of the survey questions have a short recall period of "the last 6 months."

Comment: Question 1: This question can easily be misread as a choice between "Healthy Indiana Plan" and "HIP 2.0." This potential misreading could be easily corrected as follows:

"1. Are you currently enrolled in the 'Healthy Indiana Plan 2.0,' or (also called 'HIP 2.0')?"

Response: This has been changed and updated to include "2.0."

Comment: Question 10: The wording of this question is confusing because the question does not specify a start time. "How long" could be interpreted to begin from when the individual first applied, first completed their application, or was determined eligible (but not yet enrolled). We recommend adding this clarifying clause:

"10. From the day you first applied, how long did it take you to get HIP 2.0 coverage?"

Response – Now Question 11: The survey testing showed participants had a broad understanding of "enrollment." We have made the recommended change.

Comment: Question 11: The meaning of "enrolled" may be difficult for some individuals to understand. We recommend using "started," "joined," or "began coverage with" as alternatives. Also, a respondent who knew they could never afford the monthly contribution might believe they never really had a choice between HIP Plus and HIP Basic. We recommend rewording this question as follows:

"When you enrolled started in HIP 2.0, did you have were you offered a choice between HIP Basic and HIP Plus? .

Response – Now Question 12: This survey question was adapted from a CAHPS Supplemental Medicaid Enrollment question.

Comment: Question 12: We recommend sliding this question back to come after question 15. Also, some of the listed factors on how individuals choose between the HIP plans are not clear. For example, the statement on "Making a monthly or annual contribution" could suggest the individual did not want regular monthly payments, but it could also mean that the individual found the monthly contributions were too expensive (or, conversely, preferable to more expensive per service copays.) It is unclear what "Fits within my budget" means for either HIP Basic or HIP Plus. We recommend deleting the "budget" factor and rewording other factors as follows to clarify the statements:

"How important were the following factors in helping you choose between HIP Basic and HIP Plus?"

"a. ***The amount of the monthly contributions.*** (very important, somewhat important, not at all important)"

~~"a.~~b. **I would rather make ~~a monthly or annual contribution~~ payments each month or annually instead of copays.** (very important, somewhat important, not at all important)"

~~"b.~~c. **I would rather** pay a copay at each visit ***instead of monthly payments.***"

~~"c.~~d***. I wanted*** dental and vision benefits."

~~"d. Fits within my budget."~~

"e**. I wanted to get** ~~getting~~ coverage more quickly."

Response – Now Question 13: We believe the original order helped walk respondents through their decision-making process when choosing between HIP Basic and HIP Plus. We placed question 13 first to help respondents think through the factors when deciding on a benefits package before assessing their ease of understanding, of choice, etc.

The purpose of this survey question is to assess what factors or components were important to respondents when deciding which plan would be best for them. The answer option "d" is intended to determine whether affordability was of concern to respondents during their benefits package choice. Answer option "d" has been updated to "being able to afford costs" (previously said 'fits within my budget).

Comment: Question 16: This question is leading, as the reference to "fast track" suggests the very intent (getting coverage more quickly). Given the current structure and wording, even individuals who had never heard of "fast track" would be likely to agree with the first statement and disagree with the statement that "there was nothing I could have done to get coverage more quickly." We suggest deleting question 16, and instead creating a short series of questions as follows:

"16. Is there something you could do to get coverage quickly? (yes/no/not sure)"

Follow-up: "Have you ever heard of or used $10 "fast track" payments? (yes/no/not sure)"

Follow-up, if Yes: "Please tell us whether you agree or disagree with the following statement: Choosing to make a $10 "fast track" payment would not allow me to change health plans (e.g. Anthem, MDwise, MHS)"

Response: During the survey development, we originally had a similar set up with skip patterns built in to appropriately send respondents to particular questions after they acknowledged the awareness of an option or feature that could allow them to get coverage more quickly. However, we ultimately decided not to move forward with that approach because there is a possibility that some respondents may not fully understand how the fast track option/feature works. For example, in some documents we found during our research the fast track payment is also referred to as the 'initial POWER account payment'. The comment above raises relevant points, and we have eliminated some answer options in question 17.

Comment: Question 19: We are concerned that respondents may not understand the phrase "benefits package." The questions can be easily simplified using the phrase "plan" instead of "package", as follows: "For the next question, please think about your HIP 2.0 benefit plan package. For each of the following items, please indicate whether they Which of the following items are part of your HIP 2.0 benefit plan package? Copays are payments you make at the time you visit your doctor's office, go to the hospital or get prescription drugs."

Response: During the survey testing, we assessed if participants understood use of 'benefits package'. Testing participants reported understanding the use of benefits package clearly.

Comment: Question 22: Individuals who respond "somewhat satisfied" or neutral should also have the option to offer suggestions on how to improve/what makes them only "somewhat" satisfied.

Response: While we understand the importance of following up with those reporting 'somewhat satisfied' or 'neutral' we do not have open-ended survey questions in these instruments due to length and cost concerns. The qualitative research will attempt to capture dimensions of HIP 2.0 satisfaction.