Qualified Health Plan (QHP) Enrollee Experience Survey System Technical Expert Panel (TEP)

Deliverable 4-3: Option Period 3 Meeting 1 Summary Report

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Technical Expert Panel Overview

Section 1311(c)(4) of the Patient Protection and Affordable Care Act (ACA) directs the Secretary of the Department of Health & Human Services (HHS) to establish a system that will evaluate enrollee satisfaction with the Qualified Health Plans (QHPs) offered through the Health Insurance Marketplace®.[1] The QHP Enrollee Experience Survey (QHP Enrollee Survey) draws from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) Health Plan Surveys, which measure patient/enrollee experience and are widely used to assess Medicare, Medicaid, and other commercial health plan performance. A subset of the QHP Enrollee Survey data are combined with clinical quality measures and reported as part of the Quality Rating System (QRS).

The Centers for Medicare & Medicaid Services (CMS) contracts with the American Institutes for Research® (AIR®) to support the implementation of the QHP Enrollee Survey. As part of this engagement, the AIR Project Team (Project Team) coordinates and facilitates two Technical Expert Panel (TEP) meetings per contract year. The Project Team provides the TEP with information and/or findings and requests feedback on selected aspects of the QHP Enrollee Survey, including survey development and refinement, guidance related to the survey, technical issues related to testing and fielding the survey instrument, and analysis and reporting of survey findings. The TEP then advises the Project Team on the implementation of the QHP Enrollee Survey.

The TEP consists of 19 stakeholder representatives, including consumers and consumer advocates, Marketplace administrators, health plan representatives, quality measurement experts, state officials, and subject matter experts (SMEs). Coretta Lankford, PhD, is the Project Team project director and the TEP chair.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services. Unless the context indicates otherwise, the term "Marketplace" refers to the Federally facilitated Exchanges (FFEs) (inclusive of states performing plan management functions [SPEs]), State-based Exchanges (SBEs), and SBEs on the federal platform (SBE-FPs).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Report Purpose

The purpose of the QHP Enrollee Survey TEP Meeting Report (Deliverable 4-3) is to summarize key takeaways and suggestions for the Project Team's consideration from the November 3, 2025, meeting. This report does not include the Project Team's final recommendations to CMS based on TEP inputs. The Project Team will formalize its recommendations in other planned deliverables, including the Call Letter for the QRS and QHP Enrollee Survey (Del 4-13), Select Statistical Analyses (Del 8-12), Lessons Learned Report (Del 7-11), and QHP Enrollee Survey Technical Specifications (Del 5-3).

Executive Summary of Key TEP Recommendations

Exhibit 1 presents a summary of the recommendations TEP members made at the November 3, 2025, TEP meeting.[3]

Exhibit 1. Recommendations From the November 3, 2025, TEP Meeting

Topic	Suggestions
Survey analyses	• Conduct a demographic subgroup analysis as part of the driver analysis to learn more about people with complex care needs and those who require care coordination. This could include an analysis that examines utilization, such as the number of office visits, to account for those with more complex care needs. • Use the race and ethnicity categories from the 2024 SPD-15 OMB policy directive to support the recommended subgroup analysis.
Removing survey items from composites	• TEP members supported removing survey items based on analysis looking at composite properties. These include question 30, *"In the last 6 months, how often did your personal doctor show respect for what you had to say?"* in the Doctor Communication composite, and question 34, *"In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?"* in the Care Coordination composite.

[3] One or more TEP members supported all recommendations listed in this report.

Topic	Suggestions
	• One TEP member cautioned that some of the flagged questions for potential removal may be less applicable to a healthier person but would be important to retain for someone who has more interactions with the healthcare system, such as a person with a disability or chronic condition who needs multiple tests conducted or who sees several specialists. In the latter case, it would be important to keep questions like question 34, *"In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them*?" in the doctor communication composite.
Survey revisions	• Consider adding items related to medical debt to understand additional financial impacts of coverage and copayments. • Expand the scope of items addressing delays in care to capture broader insurance-related barriers such as finding a doctor or specialist who would accept their insurance. Also, modify questions to better determine whether the delays in care enrollees experienced occurred while they were covered by their current health plan. • In reference to survey question 35, *"In the last 6 months, how often did you and your personal doctor talk about all of the prescriptions medicines you were taking?*" one TEP member suggested broadening the question to include all medications, including alternative medications and over-the-counter medications, to provide a more holistic review. • Shorten items when possible, for health literacy. For example, question 32 about interactions with a personal doctor could be shortened to *"How often did your doctor know your medical history?"* • In reference to the binary sex variable in question 61*, "What is your sex?"* a TEP member noted that this does not account for the gender diversity of the population and advocated for greater variation in gender options for all health surveys.
Survey administration	• TEP members supported extending the telephone dialing timeframe to allow survey vendors to begin contacting enrollees by phone earlier. • TEP members supported refining the prenotification letter, survey cover letter, reminder letter, and notification/reminder emails for plain language.
Reporting	• TEP members recommended that ratings be normed so that most plans score three stars. Currently most are topped out, and the scores are important because this is what people use to shop for health plans.

Meeting Summary

October 2, 2025 Pre-TEP Meeting With Consumers

Six of the 19 TEP members represent consumer perspectives. On October 2, 2025, the Project Team convened a 1-hour pre-TEP meeting via Teams® to give these members an opportunity to share reflections with the Project Team about their experiences with the QHPs in the Marketplaces (federal and state) and build upon what was discussed at the second TEP meeting of Option Period 2 on February 28, 2025. Four of the six consumer members attended this meeting. The Project Team incorporated summary points from this discussion into slides for the full November 3, 2025, TEP meeting, as described below.

November 3, 2025 Full TEP Meeting Objectives and Attendance

The Project Team convened the first TEP meeting of Option Period 3 via Teams teleconference on Monday, November 3, 2025.

The objectives of this meeting were to:

- Conduct roll call and TEP member introductions and review TEP member responsibilities;
- Recap the previous TEP meeting held on February 28, 2025;
- Share consumers' reflections about their experiences in the Marketplaces;
- Provide updates on the QHP Enrollee Survey project;
- Provide an overview of findings from analysis of the 2025 QHP Enrollee Survey data:
  - Review survey data trends including findings from driver and composite analyses.
  - Discuss topics to explore in future analysis.
- Discuss proposed refinements to the 2027 QHP Enrollee Survey.

Fifteen of the 19 TEP members attended the meeting, including four consumer members. One TEP member who could not attend the full call shared feedback in advance of the meeting via email. The Project Team addressed several of the TEP members' questions during the call and followed up via email after the meeting to ensure all questions were answered.

Appendix A. TEP Members presents a list of TEP members in attendance. Appendix B. Meeting Attendees includes Project Team members in attendance. Appendix C. TEP Agenda includes a copy of the full meeting agenda.

The following sections provide details on what the Project Team shared with TEP members and TEP member feedback throughout the meeting.

Welcome, Roll Call, and Ratification of TEP Charter

Tandrea Hilliard-Boone, PhD, TEP Task Lead, welcomed all TEP members; acknowledged the Project Team and CMS staff; facilitated roll call and introductions of TEP members, including five new QHP TEP members for 2025–2026, and briefly reviewed TEP member roles and responsibilities. Dr. Hilliard-Boone then asked each TEP member in attendance to confirm their agreement with the terms of TEP participation as outlined in the draft TEP Charter by responding in the Teams chat or verbally. All TEP members agreed to the terms; they did not request changes to the Charter language. The Project Team did not receive requested changes via email from the TEP members who did not attend the meeting. Accordingly, the TEP Charter was ratified, and the Project Team updated the Charter to include the 2025–2026 TEP Membership List.

Recap of the February 28, 2025, TEP Meeting

Dr. Hilliard-Boone briefly reviewed discussions from the February 28, 2025, TEP meeting. During that meeting, following introductions, the Project Team (1) recapped the November 4, 2024, TEP meeting; (2) heard consumer members' reflections; (3) provided updates on the survey project; (4) gathered TEP feedback on findings from the 2024 select statistical analyses; and (5) gathered TEP feedback on potential updates to the QHP Enrollee Survey. Exhibit 2 presents a summary of recommendations TEP members made at the February 28, 2025, TEP meeting.

Exhibit 2. TEP Member Recommendations From the February 28, 2025, TEP Meeting

Topic	Suggestions
Survey questions	• Consider adding questions to understand what aspects of health insurance people may find challenging or confusing to better understand health insurance literacy. • Agree with Project Team suggestion to include a global gate question that asks enrollees how they have used their health plan in the last 6 months rather than collecting this information through individual items to allow automatic skips. • Revise survey to align telehealth questions with CAHPS 5.1 to refine language and make the questions easier to navigate.
Survey refinements	• Add guidance for new sample frame variables to confirm applicability to the enrollee and not family members.

Topic	Suggestions
Survey analyses	• Conduct more detailed analysis of whether response mode varies by language preference. • Investigate potential self-selection of plans that offer telehealth by enrollees with disabilities and its implications for plan offerings. • Analyze overall satisfaction with care access by telehealth availability and disability status, particularly mobility disability. • Examine why plan ratings vary significantly by metal level while health care/provider ratings remain consistent. • Assess the impact of cost sharing on plan ratings, particularly for lower metal levels. • Investigate potential correlations among health insurance literacy, plan selection, and satisfaction. • Assess the impact of denied claims and utilization management practices on enrollee experience.

Consumers' Reflections on Experiences in the Marketplaces

Dr. Hilliard-Boone reviewed key points from the pre-TEP meeting with four of the six consumer members on October 2, 2025, in preparation for the November 3, 2025, TEP meeting.

- **Experience choosing a new plan:**
  - Consumers noted positive experiences with the Marketplace, including a more user-friendly website and a checklist feature to compare different plans. One consumer was pleasantly surprised with how straightforward the enrollment process was for them, and that they didn't need to ask for any help.
  - One consumer shopped for a new plan due to their primary care provider (PCP) leaving their old plan. The consumer unknowingly chose a plan that was new to the Marketplace and faced several challenges at the beginning of the year, including doctors and providers still being onboarded to the plan, and issues with reimbursement. This led to a long process with the state's Department of Insurance. Ultimately, the consumer was happy with the plan but suggested the inclusion of a disclaimer on brand-new plans so that consumers can make more informed decisions.
  - Consumers shared their experiences receiving customer support from the Marketplace. One consumer noted that it is often hit or miss—a consumer may need to continue to call back until they reach someone who is able to help. Another consumer shared their positive experience when moving out of state; they were easily able to make the required changes to their plan at the last minute.

- **Utilizing artificial intelligence (AI) tools for the Marketplace shopping experience:**
  - One consumer discussed their experience with using Google NotebookLM (an AI research and thinking partner that helps users understand and analyze their own documents) to help them compare several plans and choose the most cost-effective plan for their needs. Another consumer commented that while this seems like a great idea, lack of experience with AI technology would prevent them and others less experienced with AI from utilizing this tool for their own needs.
- **Perspectives on upcoming open enrollment:**
  - Consumers shared their apprehension regarding the upcoming open enrollment process due to expected cost-sharing reductions and increases to plan premiums.
  - One consumer noted having anxiety around potentially switching to a bronze plan if premiums increase.
  - Another self-employed consumer shared that they were looking for a corporate job that would provide health insurance if there is a substantial increase to their costs.
- **Experience with plans:**
  - One consumer was able to use their plan for preventive healthcare and behavioral health at affordable rates and was happy with their copay.
  - Another consumer was disappointed with the limited coverage for physical therapy in their plan. The consumer also experienced difficulties with the appeal process to request more sessions including support representatives, saying that the insurance company didn't receive the appeal and ultimately denied the appeal.
  - Another consumer shared their appreciation for the Marketplace.
- **Disclaimer for personal questions on the QHP Enrollee Survey:**
  - Consumers provided feedback that the QHP Enrollee Survey should include an explanation for asking personal demographic questions and that it should be reiterated that patient privacy will be protected.

TEP members had the opportunity to share comments and ask questions in response to the reflections shared from the pre-TEP consumer meeting.

- One TEP member who is a state-based Marketplace representative asked if consumer members were all using the federal Marketplace. The Project Team explained that some consumers on the TEP are using the federal Marketplace, while others are enrolled in state-based Marketplaces.

Project Update

Dr. Lankford provided an update on the project's completed and upcoming activities, as noted below.

- **2025 QHP Enrollee Survey.** Survey vendors collected QHP Enrollee Survey data from February through May 2025 and completed data submission. The Project Team completed data scoring and produced reports for QHP issuers and state administrators that were released in August 2025. The Project Team developed the public use file and guide for posting on the Marketplace Quality Initiatives website available here.
- **2026 QHP Enrollee Survey.** The Project Team updated the minimum business requirements for the QHP Enrollee Survey vendor program and circulated the updated materials in July 2025. The Project Team reviewed survey vendor applications and CMS conditionally approved seven survey vendor organizations to field the QHP Enrollee Survey in August 2025. AIR released the 2026 QHP Enrollee Survey Technical Specifications and trained survey vendors on the revised protocols in September 2025. The final list of approved survey vendors will be posted on the Marketplace Quality Initiatives website when available. Prior to the next TEP meeting, QHP issuers will attest to eligibility/ineligibility to collect the QHP Enrollee Survey and authorize a survey vendor via the QHP Enrollee Survey website, AIR will complete quality oversight of the survey vendors, and the vendors will initiate the 2026 QHP Enrollee Survey data collection.
- **2027 QHP Enrollee Survey and Beyond.** CMS and the Project Team have begun planning for the upcoming information collection renewal package that will be submitted to OMB in 2026.
- **2026 Updates to the QHP Enrollee Survey.** CMS revised the QHP Enrollee Survey sample frame to include three new variables that could support analyses on response patterns or be used to stratify survey results:
  - *Claim or Encounter with QHP Issuer* – Enrollee had at least one claim or encounter with the QHP issuer during the measurement year.
  - *Primary Care Provider Status* – Enrollee had a primary care provider during the measurement year.
  - *Visit with Specialty Care Doctor* – Enrollee had at least one visit with a specialty care doctor during the measurement year.

- For the 2026 QHP Enrollee Survey, CMS formalized the exception request process for oversampling above the permitted thresholds, revised vendor requirements to permit remote operations without an exception request, and created a new requirement that all vendors submit a quality assurance plan. CMS also revised the telephone script to update the introduction and reorder questions, and updated the internet survey to remove the landing page requirement and allow enrollees to begin the survey directly on the instructions page.

After sharing this update, Dr. Lankford asked TEP members if they had additional comments, questions, or reactions.

- One TEP member was not sure what remote operations referred to. The Project Team clarified that this refers to non-office-based survey vendor staff who are working remotely from home. Vendors with staff working remotely are no longer required to submit an exception request as they had to do in previous years. The most common type of remote operations are staff who are telephone dialing. For example, during COVID, survey vendors with large call centers did not have the ability to have all workers on site, resulting in a high number of staff working remotely. Now, survey vendors continue to allow staff to work remotely to incentivize and retain talented call center staff. The Project Team ensures that data security policies of survey vendors are in line with CMS policies through the quality oversight process.
- One TEP member asked if there was plain language information informing consumers about individual privacy protections for their survey responses. The Project Team confirmed that there is language included in the cover letter and introductory section of the survey informing enrollees that any information provided through the survey or to the survey vendors is kept private, and not shared externally (e.g., with a person's physician). The TEP member was happy to know that this information is included, given its importance.
- A TEP member wondered if the new sample frame variables would affect the ability to obtain survey data from people who are low utilizers of their health plans. The Project Team responded that this potential issue was considered when adding the variables to the sample frame, and clarified that the variables are not used to remove anyone from the sample frame, but rather to contextualize findings. For example, using this information, the team can conduct analyses to see if having a claim is associated with reporting higher satisfaction with the health plan.

Overview of Findings From Select Statistical Analyses

Chris Pugliese, Senior Researcher, provided an overview of survey responses, trend analyses, driver analyses, and composite analyses, using 2025 QHP Enrollee Survey data.

- **Oversampling and Number of Survey Completes.** For 2025 survey fielding, reporting units were allowed to oversample at any percentage, compared to previous years where oversampling was capped at 30%. Oversampling ranged from 35% to over 600%. Most reporting units who oversampled had a higher number of completes than those who did not oversample. CMS is proposing to permanently remove the oversampling cap on future survey administrations to help issuers meet their goals of having enough complete surveys per reporting unit.
- **Response Rates Over the Last 5 Years**. In 2025, the official survey response rate was 15.5%, a 3.5-percentage-point decline from 2024. The slight decline in the response rate over the past 5 years from 22.1% in 2021 is largely attributable to increased oversampling by many reporting units. The expanded sampling efforts have significantly increased the denominator in the response rate calculation, thereby lowering the overall rate.
- **Completes by Survey Mode.** Analysis of survey completion trends over time shows notable shifts in the percentage of completes by administration mode. While mail remains the most used mode for completing the survey, its share of total completes has been steadily declining, from 51.1% in 2021 to 41.1% in 2025. In contrast, the share of total completes by internet has increased over the past 5 years, from 32.6% in 2021 to 34.2% in 2025, which may reflect broader digital adoption and greater willingness to complete surveys online. The share of total completes by telephone has also risen, from 16.2% in 2021 to 24.7% in 2025. Discussions with survey vendors suggest that this increase may be linked to the implementation of enhanced dialing strategies, which have improved contact rates with enrollees.
- **Method of Accessing Internet Survey.** Respondents can access the internet survey through three primary methods: clicking on a link provided in an email invitation, scanning a QR code included in the survey materials, or manually entering a URL from the mailed prenotification and reminder letters. Over the past 4 years, approximately half of internet survey respondents have used the clickable link in the emails to complete the survey. However, QR code usage to access the internet survey has shown a consistent upward trend (from 18.0% in 2022 to 29.9% in 2025), indicating growing familiarity and comfort with mobile-enabled access options. Over the same time period, internet survey access by manually entering the URL has decreased, from 26.7% in 2022 to 19.1% in 2025.

QHP Enrollee Experience Survey Driver Analysis

- **Driver Analysis Overview**. Like other CAHPS surveys, the QHP Enrollee Survey includes two primary types of questions. The first type is consumer experience questions, which focus on specific, observable aspects of care—for example, question 29, "How often did your personal doctor listen carefully to you?" The second type is overall rating questions, which ask respondents to rate providers or services using a numeric scale—for example, question 39, "Using any number from 0 to 10, what number would you use to rate your personal doctor?"

  To better understand how consumer experiences influence overall ratings, the Project Team conducted a driver analysis. This analysis identified which aspects of the care experience, measured by multi-item survey composite measures, are most strongly associated with higher overall ratings—that is, which experiences drive ratings the most. By targeting improvements in these key drivers, health plans and providers can more effectively enhance patient satisfaction and support quality improvement efforts.

- **Driver Analysis Concepts.** Driver analysis relies on two central concepts: performance and importance. Performance is typically measured by the score of each driver, often transformed to a 0–100 scale for consistency between drivers. Importance reflects the strength of the relationship between a specific driver and an overall rating, commonly assessed through correlation analysis.

  Drivers that demonstrate relatively lower performance but higher importance compared to others represent critical opportunities for quality improvement. By focusing on these high-impact areas, issuers can more effectively target enhancements that are most likely to improve overall ratings and patient experience.

- **Driver Analysis: Interpreting a Priority Matrix.** A priority matrix illustrates the relationship between performance and importance for survey drivers. In this visualization, performance represented by the driver score is plotted along the x-axis, while importance measured by the correlation between the driver and an overall rating is shown on the y-axis.

  The matrix is divided into four quadrants using the median values of performance and importance. The top-left quadrant identifies the highest priority areas for improvement: drivers with relatively low performance but high importance. These represent key opportunities where targeted efforts are most likely to result in meaningful improvements in overall ratings and support quality enhancement initiatives.

- **Driver Analysis: Results for Rating of Health Plan.** The Project Team presented results for one overall rating of health plan as a detailed example of results. In this analysis, two drivers—*Access to Information* and *Getting Needed Care*—were identified in the top-left quadrant of the matrix. This indicates that these areas have relatively lower performance scores but are strongly correlated with overall health plan ratings.

  To maximize impact, plans should prioritize efforts to improve scores in these two areas. Enhancing access to information and ensuring timely, needed care are likely to yield the greatest improvements in overall health plan ratings.

- **Driver Analysis: Summary of All Results.** Across all four overall rating measures, *Getting Needed Care* consistently emerged as a top improvement area. *Access to Information* was also a key driver for improving ratings of specialist providers and health plans.

TEP members provided the following feedback on the survey driver analysis:

- A TEP member asked if there will be a demographic subgroup analysis as part of the driver analysis. They noted that it would be interesting to see a cross between demographics and the measures included in the driver analysis.
  - The Project Team noted that this analysis included all respondents but that a stratified analysis would be helpful to determine if relationships vary based on enrollee characteristics. The Team encouraged TEP members to specify any particular characteristics they are interested in including in such an analysis.
- The TEP member who asked the question remarked that they are specifically interested in people who have more complex care needs and require care coordination, such as those who undergo frequent medical testing and/or who receive specialist care in addition to having a primary care provider. Additionally, it would be interesting to conduct subgroup analyses based on their plan level, their income, and whether their plan covers just themselves or also family members. This TEP member also noted that transportation is another issue for those with multiple appointments across care settings.
  - The Project Team noted this request to examine utilization, such as the number of office visits, to account for those with more complex care needs. The Team noted, however, that data regarding income and other family members covered on the plan are not collected.
- A TEP member recommended using the more detailed race and ethnicity categories from the 2024 SPD-15 OMB policy directive to support subgroup analysis. They also raised concerns about the binary sex variable in question 61, "*What is your sex? Male or Female,*" which does not account for the gender diversity of the population, and advocated for the use of gender identity measures in health surveys.

QHP Enrollee Experience Survey Composite Analysis

- **Composite Analysis Overview.** The QHP Enrollee Survey includes 67 questions, with 26 items forming eight multi-item composite measures. This analysis assessed whether key measurement properties such as reliability and validity could be maintained after removing items from the composites.
- **Composite Analysis Steps.** This analysis builds on a similar study conducted for the Clinician & Group CAHPS survey. The steps included the following: 1) identifying all possible shorter item combinations within each composite; 2) evaluating each combination for reliability, validity, and score performance; and 3) comparing results to determine which shorter sets maintain measurement quality comparable to the full composite.
- **Composite Analysis Measurement Properties:**

  Reliability

  – Inter-Unit Reliability (IUR). IUR indicates the extent to which a measure distinguishes between reporting units with good and poor performance.

  – Effective Sample Size (ESS) to achieve IUR> 0.7. The number of respondents needed to obtain an acceptable IUR level.

  Validity

  – R-squared (R^2). Measures the proportion of the full composite score's variance that is explained by items in a shorter combination.

  – Criterion validity. The extent to which the QHP survey composite measures agree with a conceptually related measure.

  Score Consistency

  – The percentage of reporting units that do not change their "above average," "average," or "below average" national benchmark comparison when using the shortened composite instead of the full composite.
- **Composite Analysis Results.** Based on the results of these analyses, survey items that could potentially be removed from their respective composites while still maintaining acceptable measurement properties are underlined below. This does not imply all underlined items should be removed. Rather, a subset of the underlined items could be considered for removal if they are perceived as conceptually less critical than or redundant with another item.

- **Doctor Communication**
  - Question 28: How often did your personal doctor explain things in a way that was easy to understand?
  - Question 29: How often did your personal doctor listen carefully to you?
  - Question 30: How often did your personal doctor show respect for what you had to say?
  - Question 31: How often did your personal doctor spend enough time with you?
- **Care Coordination**
  - Question 32: How often did your personal doctor have your medical records or other information about your care during your visit?
  - Question 33: When your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
  - Question 34: When your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?
  - Question 35: How often did you and your personal doctor talk about all of the prescriptions medicines you were taking?
  - Question 38: How often did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
  - Question 42: How often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- **Access to Information**
  - Question 3: How often did written materials or the Internet provide the information you needed about how your health plan works?
  - Question 4: 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?
  - Question 5: How often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?
- **Enrollee Experience with Cost**
  - Question 13: How often did your health plan not pay for care that your doctor said you needed?
  - Question 14: How often did you have to pay out of your own pocket for care that you thought your health plan would pay for?

- Question 15: How often did you delay visiting or not visit a doctor because you were worried about the cost?
- Question 16: How often did you delay filling or not fill a prescription because you were worried about the cost?

TEP members provided the following feedback on the survey composite analysis:

- A TEP member expressed support for the composite analysis approach described in the slides and endorsed using data-driven methods to prioritize survey items. However, they requested more information on the motivation for reducing the survey length, and asked if there is evidence that the current survey length is a concern to respondents. The member also asked about the metrics of the data that came as an output from the composite analysis process, to see the relative merit of keeping or eliminating questions from the quantitative analysis that was completed. The Project Team noted that they would follow up via email to confirm what additional information would be helpful for decision-making.
- A TEP member inquired about inter-item correlations, and how much the items correlate in the full versus partial composite, to see if measures behave in the same way after removing questions from the composites. The Project Team clarified that this was done through the R-squared value or the coefficient of determination. Then, the team conducted an analysis of criterion validity to see whether a reduced composite showed a lower correlation. Overall, the correlations were similar for the original and reduced composites. The TEP member found this explanation helpful and noted that for their survey, they have examined bivariate correlations and matrices to assess modified composites.
- Another TEP member posited that if we can retain the same metrics for the modified composites, then why not remove all items. The Project Team clarified that the analyses represented removing one of the items from each composite. Thus, all items flagged for potential removal from all composites could not be removed while still retaining acceptable metrics.
- The Project Team asked the TEP if there were certain items they would support removing that were not conceptually important for the measure. The intention is to remove one of the underlined questions in each category.

- A TEP member supported removing question 30, *"In the last 6 months, how often did your personal doctor show respect for what you had to say?"* in the doctor communication composite, as this concept is covered by the other items. Several TEP members agreed with this.
- A TEP member agreed with removing either question 29, "*How often did your personal doctor listen carefully to you*?" or question 30, "*How often did your personal doctor show respect for what you had to say*?"
- In the care coordination composite, a TEP member supported removing question 34, "*When your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them*?" because they perceived this question as overlapping with question 33 in the composite: "*When your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?*"
- A TEP member pointed out that the flagged questions are not as applicable to people who are healthy, and are more applicable for those who have more interactions with the healthcare system. They expressed concern that removing the flagged questions might remove an important way of collecting information from individuals who have disabilities or chronic health issues, and are finding that the health system does not work as well for them compared to healthy people who are infrequent users of the health care system. Several TEP members agreed with this and thought that the question on doctor communication should be included.

Additional Survey Feedback

- A TEP member who is a medical student cautioned about results negatively impacting the physician being evaluated if patients have bias when answering questions about a personal doctor.
- A TEP member highlighted the significant lack of care in their rural state, where people frequently do not have a personal doctor. For them, the questions that ask about interactions with a personal doctor could be confusing. The member suggested shortening the questions, which would also simplify things from a health literacy perspective. For example, question 32 could be shortened to, "*How often did your doctor know your medical history?"*
- In the care coordination composite, the TEP member suggested broadening question 35, "*In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking*?" to include all medications, including alternative medications and over-the-counter medications. This would provide a more holistic view.

- A TEP member who is a consumer asked what the next steps were after receiving the QHP survey data. The Project Team responded that each reporting unit receives a quality improvement report, which goes back to issuers to show their ratings for composite scores and overall ratings. Individual questions are benchmarked to national averages, so that issuers can see where they fall in terms of national performance. Issuers can take this information to conduct quality improvement activities. Additionally, the ratings feed into the national Quality Rating System (QRS) so that consumers can see the ratings.
- A TEP member noted that the QRS is a signal to consumers about the relative quality of a plan. As a state-based Marketplace, they use this information to help hold issuers and providers responsible for quality care. However, over the years, they've found the distribution of QRS ratings to be less helpful because most plans are receiving high scores, such as a four or five on the scale. But when looking more closely at the data, they see that their plans are not scoring as high on many of the individual measures. This makes it challenging to have conversations with issuers about quality improvement because they refer to their higher overall ratings. They recommended that the ratings be normed so that most carriers score around a three. The scores are important because this is what people use to shop for health plans.
  - A TEP member appreciated this comment, as it highlighted how the survey and ratings are not only feedback for plans, but also for providers. The granularity of feedback is important, especially from people whose needs are not being met, or who are falling through the gaps. The TEP member reiterated the importance of dropping some questions to improve survey response rates and help ensure that those responding to the survey are representative of the populations receiving care.
- A consumer TEP member highlighted that some patients do not fully understand how their insurance works, and thus it is important that the questions are understandable and framed in a way patients can relate to.
- Another TEP member suggested adding questions related to medical debt to understand additional financial impacts of coverage and copayments. They also suggested expanding the scope of items addressing delays in care to capture broader insurance-related barriers such as finding a doctor or specialist who would accept their insurance, as well as modifying questions to better determine whether the delays in care enrollees experienced occurred while they were covered by their current health plan.

Proposed Refinements to the 2027 QHP Enrollee Survey

Cindy Van, Deputy Project Director, provided an overview of the survey refinement process. Ms. Van also discussed potential refinements to the 2027 QHP Enrollee Survey instrument and protocol. Ms. Van revisited past changes reviewed by the TEP, introduced new revisions the

Project Team aims to implement, and shared updates based on recent information-gathering activities, including feedback received through the Call Letter.

Timeline Overview

- Ms. Van reviewed the timeline to update the survey to help the TEP understand the steps involved in renewing clearance for the QHP Enrollee Survey under the Paperwork Reduction Act:
  - **OMB Clearance Requirement.** CMS must obtain approval from the U.S. Office of Management and Budget (OMB) for any information collection activities, including consumer testing efforts. The QHP Enrollee Survey clearance is renewed every three years. The current approval expires on September 30, 2026, covering the 2025 and 2026 fielding periods.
  - **Renewal Process.** To maintain clearance to conduct the survey, CMS submits an updated Information Collection Request package to OMB. This package confirms the ongoing need for data collection and documents any proposed changes to the survey.
  - **Public Comment Periods.** The OMB process includes two comment periods:
    - 60-Day Comment Period: CMS posts the package materials in the Federal Register for public review and feedback.
    - 30-Day Comment Period: CMS revises the package based on comments received during the 60-day period and posts materials to the Federal Register for public comment review and feedback. Feedback will be used to develop the final OMB package for submission and approval.
  - **Internal Timeline.** Preparations for the next OMB package will begin in 2025 to ensure timely submission. These activities will overlap with Call Letter development, so CMS will incorporate feedback from both processes into the final OMB package.

Survey Refinement Considerations

- Refinements to the QHP Enrollee Survey affect the CMS QRS because the survey data inform several QRS measures. Since revisions to the QHP Enrollee Survey items can influence scoring and reporting, we work closely with CMS and the QRS team to ensure alignment between the survey and measure reporting requirements.
- Although the QHP Enrollee Survey is not a CAHPS survey, it incorporates elements from the CAHPS Adult Commercial Health Plan survey to allow comparisons across programs such as Medicare and Medicaid.
- Any changes that increase respondent burden require OMB clearance.
- Proposed updates are included in the Draft Call Letter for stakeholder review and feedback.

Approved Revisions for the 2027 QHP Enrollee Survey

- CMS has approved the following changes to the survey administration protocol pending OMB approval:
  - Enabling oversampling at any level starting with the 2027 ratings year.
  - Customizing each enrollee's mail and internet survey instrument by replacing "Qualified Health Plan (QHP)" with the issuer's name on the cover page and internet survey—an update strongly supported by TEP members and consumer representatives for recognizability of the survey.
  - Adding a third email reminder to the data collection protocol.
  - Revising the prenotification letter, survey cover letter, reminder letter, and notification/reminder emails for plain language. AIR made similar edits to the telephone scripts that were posted in September 2025 for use in the 2026 QHP Enrollee Survey.
- CMS has approved the following changes to the QHP Enrollee Survey instrument:
  - Removing the questions associated with the *Medical Assistance with Smoking and Tobacco Use Cessation* measures and associated questions because the measure steward is retiring the measure and shifting to using a digital measure.
  - Adding gate questions to improve question flow and eliminate confusion between "not applicable" and "never" responses.
  - Revising the telehealth question wording to align with CAHPS 5.1 standards.
  - Updating race and ethnicity items for compliance with a 2024 OMB statistical policy directive, balancing the need for granularity with statistical reliability.
- These refinements reflect feedback from the TEP and will be incorporated into the 2027 OMB submission package.

Refinements Under Consideration: Extend Telephone Timeframe

- Extend the telephone follow-up timeframe by allowing vendors to start dialing earlier than the current protocol (which begins on Day 55 after sending the second survey mailing on Day 34). This change would provide more flexibility for completing six required attempts.
- Vendors requested this adjustment due to challenges meeting current requirements for varied call times and days within the 19-day calling window. Moving the start date forward would help maintain compliance while improving operational feasibility.

TEP members provided the following feedback and recommendations:

- Several TEP members expressed agreement with the refinement to extend the telephone timeframe.
- A TEP member asked if vendors leave messages after telephone attempts. The Project Team answered that vendors do not leave messages due to privacy concerns.
- A TEP member asked about how the Project Team addresses spam calling. The Project Team responded that there are several ways for people to access the survey, including submitting the mail survey they received or completing the email survey, which are alternative options for those who may think the vendor calling is spam.

Update on Questions Previously Considered for Addition

Ms. Van provided an update to the TEP on several items that were previously considered for addition, but will no longer be recommended for the OMB package:

- **Addition of Net Promoter Score.** 2025 Call Letter feedback was mixed. Medicare Advantage and Prescription Drug Plans (MA & PDP) CAHPS found that questions were too similar to the overall ratings and had limitations in scoring.
- **Addition of Perceived Unfair Treatment Question.** 2025 Call Letter feedback was mixed. This question is now being removed from MA & PDP CAHPS.
- **Addition of Primary Language Question.** 2024 Call Letter feedback was mixed. This question was recommended for addition based on alignment with the 2011 data collection standards. These standards are now under revision.
- **Addition of Gender Identity Question.** 2024 Call Letter feedback was mixed. Based on alignment with current administration priorities, this question is no longer recommended for addition.

Ms. Van then asked the TEP members if they had any comments or questions in response to the proposed refinements.

TEP members provided the following feedback and recommendations:

- A TEP member asked if people have the option to call the survey vendor directly to complete the telephone survey. The Project Team responded that vendors are required to open telephone lines for inbound calls starting on day one of fielding. The prenotification letters and emails that are sent to enrollees include a customer service line for enrollees to call to complete the survey.
- Several members expressed support for the plain language refinements.

- A TEP member asked if the Project Team has considered any of the impacts from changes in enrollment prompted by decisions made on the premium tax credits. The Project Team does not plan to add any additional items to the 2026 survey in preparation for changes to premium tax credits. CMS may consider using data from the 2026 survey administration to see how changes to premium tax credits affect enrollees' experience with their health plan, including using demographic information to see who is enrolling.

Next Steps

The Project Team provided a high-level overview of the next steps for the QHP Enrollee Survey in the coming months, which will include the following activities:

- Continuing to provide oversight of the 2026 QHP Enrollee Survey administration.
- Following up with TEP members in the coming months to (1) answer any questions that were not answered during the meeting and (2) obtain additional feedback, if any.
- Share the TEP Meeting 1 Summary once it is available on the CMS Measures Management System (MMS) site.

The Project Team also shared that the next TEP meeting will occur in spring 2026. The team will follow up via email to share updates.

Appendix A. TEP Members

QHP Enrollee Survey TEP Attendance: Option Period 3 Meeting #1	X if Attended
Noemi Altman, MPA Senior Survey Research Associate Consumer Reports, New York, NY	X
Kellan Baker, PhD Executive Director and Chief Learning Officer Whitman-Walker Institute, Washington, DC	
Steve Butterfield, MA Senior Director of State Public Policy Blood Cancer United, Washington, DC	X
Shirley Dominguez Consumer/Navigator Community Engagement Specialist (Epilepsy Alliance)	X
Blake Hodges, MS Senior Consultant Kaiser Foundation Health Plan, Denver, CO	X
Todd Hughes Director, CA Health Interview Survey UCLA Center for Health Policy Research, Los Angeles, CA	X
Emily James Consumer Chef, Los Angeles, CA	X
Itisha Jefferson, BS, Medical Doctorate Candidate Consumer and Family Caregiver Loyola University, Stritch School of Medicine, Maywood, IL	X
Paloma Luisi, MPH Director of the Bureau of Quality Measurement & Evaluation New York State Department of Health, Albany, NY	X
Christine Monahan, JD Assistant Research Professor Georgetown Center on Health Insurance Reforms, Washington, DC	X
Kimberly Morgan Director, Quality and Performance Measurement Point32Health	X

QHP Enrollee Survey TEP Attendance: Option Period 3 Meeting #1	X if Attended
Erin O'Rourke, BS Executive Director of Clinical Performance and Transformation America's Health Insurance Plans, Washington, DC	X
Alex Sanchez, MBA Chief Experience Officer BeWell, New Mexico's Health Insurance Marketplace, Albuquerque, NM	X
Riley Simmington Consumer Small Business Owner and Contractor of Professional/Administrative Services, Chicago Illinois	
Keri Setaro, BFA Consumer; Self-Employed Montclair, NJ	
Ivan Smith Consumer Landscaper	X
Jennifer Sullivan Director of Health Coverage Access Center on Budget and Policy Priorities, Washington, DC	
Kristin Villas, BA, MPA Senior Policy Analyst Washington Health Benefit Exchange, Olympia, WA	X
Silvia Yee Senior Staff Attorney Disability Rights Education and Defense Fund, Berkeley, CA	X

Appendix B. Meeting Attendees

Centers for Medicare & Medicaid Services (CMS) Attendees
Due to a federal government shutdown that was in effect on the meeting date, members from CMS were not in attendance.

QHP Enrollee Survey Project Team Attendees
Coretta Lankford, Project Director and TEP Chair American Institutes for Research (AIR)
Tandrea Hilliard-Boone, TEP Task Lead American Institutes for Research (AIR)
Cindy Van, Senior Researcher American Institutes for Research (AIR)
Chris Pugliese, Senior Researcher American Institutes for Research (AIR)
Akua Asante, TEP Coordinator American Institutes for Research (AIR)
Meera Bhalla, Research Associate American Institutes for Research (AIR)
Zoe Sousane, Project Specialist American Institutes for Research (AIR)
Parakh Patel, Research Associate American Institutes for Research (AIR)

Quality Rating System Project Team Attendees
Suzanne Singer, Associate Booz Allen Hamilton (BAH)
Katie Mackoul, Senior Consultant Booz Allen Hamilton (BAH)
Nyaradzo Longinaker, Lead Scientist Booz Allen Hamilton (BAH)
Christina Marsh, Social Scientist Booz Allen Hamilton (BAH)
Emma Dreher, Program Manager Booz Allen Hamilton (BAH)

Appendix C. TEP Agenda

QHP Enrollee Survey TEP Option Period 3 Meeting 1

Monday, November 3, 2025, 1:00–3:00 pm Eastern Time (ET)

Meeting ID: 217 666 469 656 9

Passcode: 7iL3Yx2E

Web Conference Link

Time (ET)	Topic
1:00–1:30 p.m.	**Welcome and Introductions** • Welcome members and conduct roll call. Introduce new member(s). • Review the meeting agenda and objectives. • Review TEP roles and responsibilities. Ratify the TEP Charter. • Recap the previous TEP meeting held on February 28, 2025.
1:30–1:45 p.m.	**Consumers'** Reflections • Consumer TEP members share their experiences with QHPs in the Exchanges.
1:45–1:55 p.m.	**Project Update** • Provide an overview of recently completed and upcoming activities.
1:55–2:20 p.m.	**Overview of Findings From 2025 QHP Enrollee Survey Analyses** • Review survey data trends including findings from driver and composite analyses. • Discuss topics to explore in future analyses.
2:20–2:55 p.m.	**Proposed Refinements to the 2027 QHP Enrollee Survey** • Discuss approved and proposed refinements to future administrations of the QHP Enrollee Survey.
2:55–3:00 p.m.	**Meeting Wrap-Up** • Review next steps.

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