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

## Deliverable 4-3: Option Year 2 Meeting 2 Summary Report

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# Contents

## Technical Expert Panel Overview

Section 1311(c)(4) of the Patient Protection and Affordable Act (ACA) directs the Secretary of the Department of Health & Human Services (HHS) to establish a system that will evaluate enrollee satisfaction with Qualified Health Plans (QHPs) offered through the Health Insurance Exchanges®.[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 is combined with clinical quality measures and reported as part of the Quality Rating System (QRS).

The Centers for Medicare & Medicaid Services (CMS) contracted 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 TEP advises the Project Team on the implementation of the QHP Enrollee Survey. 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 2024–2025 TEP consists of 16 stakeholder representatives, including consumers and consumer advocates, Exchange administrators, health plan representatives, quality measurement experts, state officials, and subject matter experts (SMEs). Coretta Lankford, PhD, is the project director and TEP chair for the 2024–2025 QHP Enrollee Survey TEP.

## Report Purpose

The purpose of the QHP Enrollee Survey TEP Meeting Report (Del 4-3) is to summarize the TEP's key takeaways and suggestions for the Project Team's consideration.[3] This report does not include the Project Team's final recommendations to CMS based on TEP inputs. The Project

[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 "Exchanges" (also known as "the 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.
[3] One or more TEP members supported all recommendations listed in this report.

Team will formalize its recommendations based on TEP feedback through other 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).

## Meeting Summary

The Project Team convened a 1-hour pre-TEP meeting for TEP members representing consumer perspectives via Zoom® teleconference on Monday, February 3, 2025. Four of the five consumer members attended the meeting. This pre-TEP meeting provided an opportunity for consumer representatives on the TEP to share reflections with the team about their experiences with QHPs in the Exchange and build upon what was discussed at the first TEP meeting of Option Year 2 on November 4, 2024. The team incorporated summary points from this discussion into slides for the next TEP meeting.

The Project Team convened the second TEP meeting of the Option Year via Zoom teleconference on Friday, February 28, 2025. Twelve of the 16 TEP members attended the meeting, including four consumer members. The Project Team sent an email to TEP members after the meeting seeking additional insights into topics discussed during the meeting. The Project Team did not receive any additional feedback.

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

The objectives of the February 28, 2025, QHP Enrollee Survey TEP meeting were to:

- Conduct roll call and TEP member introductions and review TEP member responsibilities;
- Recap the recommendations from the November 4, 2024, TEP meeting;
- Share consumers' reflections about their experiences in the Exchanges;
- Provide updates on the QHP Enrollee Survey project; and
- Gather insights and feedback on:
  - Findings from 2024 select statistical analyses and
  - Potential updates to the QHP Enrollee Survey.

Exhibit 1 presents a summary of recommendations TEP members made at the February 28, 2025, TEP meeting.

**Exhibit 1. 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.<br>• Agree with including 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.<br>• Revise survey to align telehealth questions with CAHPS 5.1 to refine language and make the questions easier to navigate. |
| **Survey analyses** | • Conduct more detailed analysis of language preference on response mode selection.<br>• Investigate potential self-selection of plans that offer telehealth by enrollees with disabilities and its implications for plan offerings.<br>• Analyze overall satisfaction with care access by telehealth availability and disability status, particularly mobility disability.<br>• Examine why plan ratings vary significantly by metal level while health care/provider ratings remain consistent.<br>• Assess the impact of cost sharing on plan ratings, particularly for lower metal levels.<br>• Investigate potential correlations between health insurance literacy, plan selection, and satisfaction.<br>• Assess the impact of denied claims and utilization management practices on enrollee experience. |
| **Survey refinements** | • Add guidance for new sample frame variables to confirm applicability to the enrollee and not family members. |

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 TEP members, acknowledged the Project Team and CMS staff, facilitated roll call and introductions of TEP members in attendance, and briefly reviewed TEP roles and responsibilities.

## Recap of the November 4, 2024, TEP Meeting

Dr. Hilliard-Boone briefly reviewed discussions from the November 4, 2024, TEP meeting. During that meeting, following introductions, the Project Team (1) recapped the March 1, 2024, TEP meeting and consumer members' reflections; (2) provided updates on the survey project; (3) gathered TEP feedback on the 2024 QHP Enrollee Survey response rate, trend, and TEP-recommended analyses; and (4) gathered TEP feedback on potential updates to the QHP

Enrollee Survey. Exhibit 2 presents a summary of recommendations TEP members made at the November 4, 2024, TEP meeting. The Project Team expressed gratitude to the TEP for this feedback and noted that it looks forward to continued discussions about how CMS can potentially advance these recommendations.

### Exhibit 2. TEP Member Recommendations From the November 4, 2024, TEP Meeting

| Topic | Suggestions |
|---|---|
| **Survey administration** | • Implement the new requirement to include QR codes on survey materials.<br>• Include a third reminder email, labeled as "final reminder," to improve response rates and ensure proper timing between reminders.<br>• Simplify and clarify gate questions to enhance usability such as by including a list of examples of what it means to access your health plan. Share mockup of the revised questions with the TEP for review. Lengthen the survey administration period to increase response rates among racial/ethnic minority and younger populations.<br>• Revise survey title to include issuer and Marketplace names, avoiding less commonly understood terms like " QHP (Qualified Health Plan)," considering that QHP may not be widely recognized.<br>• Assess potential impacts of shifting the sample frame anchor date on issuers as there could be challenges with the auditor and relocking files to resend to the vendor. |
| **Survey presentation** | • Use plain, clear language in data collection explanations on the survey such as the statement explaining the purpose of demographic questions: “We ask these next questions to learn more about people who have health insurance like yours.”<br>• Avoid using ambiguous terms like “your health plan” to reduce respondent confusion. |
| **Survey questions** | • Generally, the TEP favored the inclusion of the perceived unfair treatment question. However, some members were unsure about how actionable the question is as written because issuers will not be able to tie the unfair treatment to a specific provider. Consider an additional question that provides information about which provider may have discriminated against an enrollee so issuers can follow up. An open-ended question may be helpful here to capture additional details. If that is not within the survey’s scope, including information on who to contact if this has occurred may be helpful.<br>• Include the primary language spoken at home question on future surveys with an open-ended write-in option, as it could provide useful information.<br>• Include Net Promoter Score (NPS) question as it is widely used across different industries. Consider including an open-ended question following the NPS question to help issuers measure experience in ways that are not otherwise captured on the survey.<br>• Consider including more specific and actionable questions related to different aspects of customer service and enrollee experience.<br>• Align race/ethnicity questions with updated data standards.<br>• Consider aligning telehealth question language with the CAHPS 5.1 language but note that it is important to determine whether the satisfaction level refers to the actual care received or the telehealth feature itself. |

| Topic | Suggestions |
|---|---|
| **Analyses** | • Assess enrollees' satisfaction with telehealth, focusing on service efficiency, quality, and its effectiveness as a substitute for in-person visits to address health concerns.<br>• Conduct subgroup analyses examining telehealth use among different populations (by race, ethnicity, disability, and other characteristics) to determine its impact on disparities. |

## Consumers' Reflections on Experiences in the Exchange

Dr. Hilliard-Boone reviewed key points from the pre-TEP meeting with the four consumer members on February 3, 2025.

- **Reactions to proposed changes discussed at the November 4, 2024, TEP meeting:**
  - Consumers agreed with including explanations for any new demographic or "About You" questions. They also agreed that those questions should be optional.
  - Regarding the potential addition of a likelihood to recommend a health plan to others (i.e., NPS) question, one consumer liked the idea of a "Zocdoc" style rating of how helpful a plan was for other consumers.
- **Interactions with Marketplace websites and representatives:**
  - Consumers agreed that the Marketplace website does not include accurate or up-to-date information regarding what medications and providers are covered or in network under specific plans, as providers frequently change what insurance they take. Additionally, some specialists are not even listed on the portal, and it is difficult to get a straight answer on whether certain specialists take a specific insurance. Calling the doctor's office is the only way to know for sure what is and is not covered.
  - Consumers continue to experience difficulties with customer service. One consumer reported that customer service was not willing to answer their questions unless they were enrolling in the plan. Customer service also frequently transfers consumers to sales representatives who are not appropriately informed to answer consumers' questions about medications, providers who are in network, or details of the plan.
- **Feedback on open enrollment:**
  - Many plans increased considerably in price this year. This was especially challenging for those who were on the same plan for several years and who had to shop around for a new plan because of a price hike. In some cases, hospitals that used to accept certain plans no longer do.
  - Consumers experienced issues with auto-enrollment. Many people who rely on automatic re-enrollment were not aware of the changes being made to their plan.

Consumers noted that there should be a reminder about auto re-enrollment so that consumers can update their application throughout the year and be made aware of any forthcoming changes. This way, they can make an informed decision about whether to continue with their plan while avoiding any gaps in coverage.

  - One consumer said that during open enrollment, customer service did not explain details of the plan. Rather, the consumer used the comparison tool to learn about the different plan options.

- **Interactions with providers:**
  - Consumers noted that frontline staff at providers' offices often do not know the difference between insurance plans, such as Medicare, Medicaid, the Federal Marketplace/Exchange, and State-based Exchanges. These staff should be better educated on these plans so that they can respond appropriately to consumer inquiries.
  - Consumers reported that they feel that they are treated differently based on what plan they have. One consumer recalled the experience they had when their daughter was denied a vaccine after a provider learned what insurance they had. Another consumer noted that there is differential treatment regarding payments for services. The grace periods that people with Marketplace plans are afforded through the ACA, which extend payments up to 90 days, are viewed less favorably because when a patient is in a grace period, the provider runs the risk that they won't get paid.
- **Perspectives on health insurance literacy:**
  - Consumers agreed that health insurance literacy is critical for navigating the Marketplace and health care system and were glad that the QHP Enrollee Survey includes two questions to assess a person's level of confidence with health insurance.
  - A consumer suggested that insurance plans should create concise, easy-to-understand videos that explain key insurance terms. The video could have simple animation, as well as a training completion certificate. Consumers shared that although some plans have a welcome video that covers basic terminology, the videos do not explore the nuances of insurance terms, such as the difference between a co-pay and co-insurance.
  - Consumers felt that it would be helpful to assess exactly what they do not understand or are having difficulty with. There are many gaps that may exist in health insurance literacy, such as key terms, the payment process, or what steps to take after acquiring a plan.
  - A consumer who is also a navigator explained that often the summary of benefits on the Marketplace website advertises rates that are only for value providers. Value providers

have a discounted rate, and the rate for other providers is different and higher. Plans are not always transparent about this type of information.

  - One consumer shared an example where customer service switched a consumer who had a sponsored premium plan to a bronze plan without explaining that, although the plan may have a lower premium, the plan has a much higher deductible and out-of-pocket maximum. The consumer did not realize this until it was time to visit a provider.

**TEP members shared comments and asked questions in response to the reflections shared from the pre-TEP consumer meeting.**

- One TEP member shared that many consumer reflections resonated with them, particularly regarding poor customer service experiences. They suggested alternative approaches for handling detailed consumer inquiries, such as scheduling a follow-up call to provide more information or sending additional details in an accessible format. They emphasized that clarification is often necessary, especially when consumers struggle to understand plan differences or provider network details. Without further engagement, consumers may not understand the full picture, leading to lower satisfaction with their plans.
- Another TEP member expressed disappointment that confusion persists at doctor's offices regarding insurance types, benefits, and vaccine provisions for children. They stressed that it should not be the consumer's responsibility to educate front desk staff on QHPs versus Medicaid or other plans; rather, this should be addressed by the plan issuers.
  - A consumer TEP member highlighted the importance of health insurance literacy and noted that there may be differences in literacy levels across states based on their Medicaid expansion status.
- A TEP member asked about the origin of the term "value providers." A TEP member who is a consumer and navigator explained that, when consumers browse plans in the Marketplace, they see a summary that may indicate a $0 charge for a primary care visit. However, this applies only if they visit a designated "value provider." Some plans have partnerships with specific clinics, and while this information is included in the Summary of Benefits and Coverage (SBC), it is not prominently displayed on the Marketplace websites. The TEP member emphasized that the lack of transparency may mislead consumers about their expected costs if they visit a provider outside of this designated group.
- A TEP member asked whether "value providers" were simply in-network providers or if there was a meaningful distinction. The TEP member who is a consumer and navigator clarified that value providers are distinct from standard in-network providers. Beyond the typical agreement between an insurer and a provider, value providers participate in additional partnerships that encourage members to use their services due to lower costs.

For instance, under a state-based Marketplace plan, a computed tomography scan at a designated clinic may cost significantly less than getting the scan at another in-network facility. Similarly, primary care visits may be available at a reduced or even $0 cost through these providers. This tiering system creates an additional layer within the broader in-network structure, allowing insurers to guide members toward lower cost providers.

  - Another TEP member noted that the lack of clarity in SBCs extends beyond provider tiering and often affects information about costs for services such as hospital outpatient department visits.
  - A TEP member noted that broadening the provider network by partnering with different types of providers could help plans meet network adequacy standards.

## Project Update

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

- **2024 QHP Enrollee Survey.** The Project Team produced a public use file and guide for using the file in October 2024.
- **2025 QHP Enrollee Survey.** The 2025 survey data collection cycle started in June 2024 with survey vendor solicitation and approval. The final list of approved survey vendors was posted in October 2024. Issuers attested to eligibility and selected survey vendors in January 2025. Survey vendors are in the process of fielding the survey from February to May 2025. AIR is conducting oversight of data collection and preparing for data submission. Prior to the next TEP meeting, survey vendors will submit all survey data and AIR will process survey data and produce reports for QHP Issuers and states.
- **2026 QHP Enrollee Survey and Beyond.** The 2025 Draft Call Letter proposing future survey revisions for public comment is expected to be posted in March 2025.
- **2025 QHP Enrollee Survey Update.** Based on feedback from the TEP and the public, CMS made the following two major updates to the 2025 survey administration:
  - **New Survey Mode.** CMS introduced an optional Chinese language internet survey mode, including both the online survey and notification/reminder emails.
  - **Updated Communication.** CMS revised prenotification and reminder letters to require the use of QR codes for easier access.
- **Update on Oversampling.** Based on TEP and interested party feedback, for 2025 survey administration, CMS permitted survey vendors to submit exception requests to oversample beyond the current guidance, which requires oversampling at 5% increments to not exceed 30%. Press Ganey, Qualtrics, and CSS have approved exception requests in place to

oversample beyond current guidance for select reporting units. Based on vendors' Report #3 (Final Client List), submitted February 7, 2025:

- Vendors will field the survey on behalf of 353 total QHP reporting units.
- 234 (66%) of all reporting units will oversample; 88 will oversample beyond the current guidance, ranging from 35% to 760%; and 146 will oversample at or below 30%.

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

- A TEP member asked if vendors must state who they are going to oversample, and if the oversample is a simple random sample. The Project Team shared that vendors could oversample up to 30% extra over the standard survey sample size of 1,300. When drawing the sample, vendors pull a simple random sample of enrollees included in the sample frame provided by the QHP issuer. A member also inquired if vendors need to provide an explanation for oversampling. The Project Team responded that vendors do need to provide an explanation for oversampling, and it is typically to get more complete surveys to meet the minimum number of completes required to have reportable results. In response, a TEP member reasoned that vendors can likely see responses from specific patient categories when receiving a greater number of completes, incentivizing the vendor receiving more completes. The Project Team confirmed that this is one reason why vendors want more complete surveys. Additionally, vendors must receive a minimum of 100 completes to have reportable results.

- A TEP member asked if there was a Chinese-language version of the survey prior to this year's implementation of the Chinese internet survey. The Project Team clarified that there was only a mail and telephone version of the Chinese survey prior to this year. The internet version of the Chinese survey is new this year.

- A TEP member inquired about a vendor that wanted to oversample by 760%, and asked what percentage of the total eligible population was being sampled in this scenario. Ms. Cindy Van, Deputy Project Director, explained that although this appears to be a large oversample, because this was a large plan, the number of enrollees sampled was only about 11% of the eligible population.

## Overview of Findings From Select Statistical Analyses

Chris Pugliese, senior researcher, provided an overview of survey response and trend analyses from 2024 QHP Enrollee Survey data.

- **Response Analysis Findings (Language by Administration Mode).** Spanish language respondents saw a significant increase in telephone survey completes in 2024. The proportion of Spanish-language respondents completing the survey by phone rose by approximately 21% compared to 2023, while the proportion completing via internet and mail declined. These shifts are likely due to revised dialing strategies and new technology implemented by vendors, which improved connection rates with respondents.
- **Response Analysis Findings (General Health by Administration Mode).** Survey administration mode varies based on respondents' self-reported general health. Respondents who rate their general health as poor are more likely to complete the survey by telephone, compared to those with better health ratings. A similar trend was observed when analyzing survey mode by respondents' mental health ratings. These findings highlight the importance of maintaining the phone response mode to ensure that populations with worse health can participate in the survey.
- **Ratings of Health Plan by Metal Level.** Overall ratings of health plans differ substantially by the metal level of a respondent's health plan, but ratings of health care, primary care provider, and specialist providers do not.

  This aligns with the intended design of metal levels—while the amount of cost-sharing differs between metal levels, the quality of care should remain consistent. Lower health plan ratings among consumers may reflect dissatisfaction with cost-sharing requirements rather than the quality of care received.
- **Telehealth Access and Disability.** Most individuals with disabilities report similar or higher access to telehealth compared to those without disabilities. Slight differences were observed, with individuals who experience difficulty hearing or seeing reporting slightly lower access to telehealth. However, those with mobility limitations, including difficulty walking, dressing, bathing, or running errands, reported higher access to telehealth.

Mr. Pugliese posed the following discussion questions to TEP members:

**Questions Posed to the TEP:**

**What impressions or questions do you have about the survey analyses (e.g., reason for response rate increase)?**

**Does the TEP have any additional suggestions for potential survey analyses?**

TEP members provided the following feedback on the survey analyses.

**Response Rates and Survey Language Mode**

- A TEP member asked about the overall response rate for 2023 and 2024. The Project Team confirmed that it was 18.3% but clarified that the results presented during the TEP meeting reflect completion rates, not response rates. The TEP member suggested including overall response rates for better clarity.
- The TEP member inquired whether the survey language referred to the language used for completion or the enrollee's primary language at home. The Project Team confirmed that it was the language of survey completion.
  - The TEP member sought confirmation that, for example, a survey presented in Chinese was completed in Chinese. The Project Team confirmed this and added that the slide only shows telephone and mail as options for Chinese respondents because the internet version of the Chinese survey was not available for the 2024 survey. The internet version of the Chinese survey was added as an option for 2025 fielding.
- The TEP member also noted an increase in telephone survey completions, particularly for Spanish-speaking respondents. The Project Team attributed this to a change in dialing practices by a survey vendor, leading to improved contact rates. The TEP member mentioned that this aligns with Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) research, which shows that Spanish language preference influences response mode selection.
- A TEP member noted that in 2023, the Spanish-speaking population of respondents seemed lower than expected but they assumed that the number was closer to the national rate in 2024 due to improved dialing strategies. The Project Team explained that Spanish-speaking respondent numbers increased in 2024.
  - The TEP member expressed interest in more detailed survey analysis related to language and will follow up with specific suggestions.
- One TEP member observed a decline in Spanish-language internet survey completions. The Project Team confirmed this but noted that overall, internet completion rates have increased and are stable. The Project Team noted that there may be further shifts in 2025 as dialing strategies evolve.

**Survey Mode Trends and Contact Information**

- The TEP member asked about the sequential order of survey mode administration. The Project Team confirmed that the survey is administered in the following order: mail, internet, and telephone follow-up.

- The TEP member also inquired about who provides enrollee contact information. The Project Team confirmed that issuers provide enrollees' contact information. The Project Team noted that issuers are incentivized to ensure accurate and complete contact details, including email addresses, to meet the 100-response completion threshold for scoring.

**Survey Results and Reporting**

- A TEP member asked where survey results are reported. The Project Team explained that the survey results feed into the QRS and quality improvement (QI) reports. Issuers receive QI reports with overall ratings and composite measure scores, demographic information about respondents, and response rates at the reporting unit level.
- The TEP member also asked whether issuers could compare their results with those of others. The Project Team confirmed that issuers see their overall ratings and composite measure scores benchmarked against the national average, indicating whether they performed above or below the national average.

**Telehealth and Disability**

- A TEP member noted little difference in telehealth use between individuals with and without disabilities. The Project Team confirmed that interpretation of the finding was correct. The TEP member posited that individuals needing personal care assistance or help with errands use telehealth more, which may indicate higher self-selection rates into plans that offer telehealth. The Project Team agreed and explained that mobility disabilities and developmental disabilities may drive this trend due to the effort required for in-person visits.
- The TEP member questioned whether the self-selection could create an incentive for plans to limit telehealth offerings, potentially discouraging enrollment by people with disabilities and reducing costs. The Project Team acknowledged that this was an important point that the team had not yet explored. The Project Team also added that out of all respondents, only about one third of respondents reported having telehealth access, while two thirds indicated they did not have access. The TEP member emphasized the importance of ensuring broad telehealth availability to avoid plans disincentivizing coverage for certain groups. They also noted that telehealth gained prominence during the pandemic and should remain widely accessible.
- Another TEP member suggested analyzing satisfaction with care access based on telehealth availability and disability status, particularly mobility disability as that may be where a difference exists. The Project Team supported this idea, proposing to further stratify by disability type to see whether satisfaction or experience ratings vary by access to telehealth.

**Case-Mix Adjustment**

- A TEP member asked whether the team adjusts scores for patient mix or case mix based on preferred language or survey language mode to ensure fair comparisons. The Project Team confirmed that it adjusts scores for survey language mode, as is standard for most CAHPS surveys.
- The TEP member asked whether adjustments are made for physical and mental health status. The Project Team confirmed that general and mental health are included as case-mix adjusters.

**Health Plan Ratings and Cost-Sharing**

- One TEP member asked why there were significant differences in health plan ratings by metal level but not in ratings for health care or providers. The Project Team explained that metal level differences impact cost-sharing, but care quality should remain consistent across plans. The Project Team suggested that lower ratings for catastrophic and bronze plans may be driven by these plans having higher out-of-pocket costs when care is needed, compared to gold or platinum plans, which have lower out-of-pocket costs.
- Another TEP member built on this, referencing earlier discussions with consumer representatives and navigators. They highlighted potential gaps in health insurance literacy, where some consumers focus on lower premiums without understanding other potential costs like deductibles and co-pays.
- The TEP member asked whether health insurance literacy levels correlate with plan satisfaction. The Project Team confirmed that the survey includes two questions on health insurance literacy (confidence in understanding health insurance terms and ability to use health insurance coverage) and they both have a positive correlation with overall ratings of health plans.
- Another TEP member suggested analyzing whether delaying care due to cost impacts plan ratings. The Project Team agreed and proposed assessing whether health insurance literacy and cost-sharing experiences affect plan ratings, stratified by metal level.
- The TEP member added that their organization uses a replica of the CAHPS survey and noted that about 15% of their survey respondents reported not seeking care. For those who tried but couldn't access care, ratings were significantly lower. The Project Team emphasized the need to separate these populations for analysis, where possible.

**Utilization and Denied Claims**

- One TEP member inquired about survey questions on utilization management practices, denials, and appeals. They observed that many survey items focus on provider experience

rather than health plan operations. The Project Team noted that consumer experience with health plans and providers is the goal of the QHP Enrollee Survey.

- The TEP member questioned whether past efforts explored denied claims and the consumer experience with accessing benefits. The Project Team noted that the survey has typically been more general in scope and does not ask enrollees about these types of experiences but agreed that a deeper dive into utilization management practices would be valuable.

## Proposed Refinements to the QHP Enrollee Survey

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

### *Survey Refinement Considerations*

- **U.S. Office of Management and Budget (OMB) Clearance and the Paperwork Reduction Act (PRA).** CMS must secure clearance from OMB for any information collection efforts related to consumer testing for the QHP Enrollee Survey. The survey undergoes renewal every 3 years. The OMB approval process takes approximately 6–8 months to complete. This clearance process is mandated by the PRA, which aims to (1) manage the information that agencies request from the public; (2) ensure data quality for informed decision-making; and (3) safeguard private information.
- **Implications for the QRS.** Refinements to the QHP Enrollee Survey impact the QRS, as the survey data directly informs QRS measures.
- **Relation to CAHPS Surveys.** Although the QHP Enrollee Survey is not a CAHPS survey, it is based on the CAHPS Health Plan Survey, Version: Adult Commercial Survey 5.1 . This alignment allows for comparisons across product lines (e.g., Medicare, Medicaid); however, QHP Enrollee Survey refinements may diverge from CAHPS updates.
- **Survey Refinement Process.** Ms. Van reviewed a timeline to help the TEP visualize current and upcoming project activities, including the steps that must take place before the survey changes can be implemented:
  - **Fielding Schedule Overview.** The annual fielding schedule for the QHP Enrollee Survey takes place from February to May. Technical specifications for the survey are revised and released by early October each year. The current survey version is approved through September 2026, covering the 2025 and 2026 fielding periods. This approval

expires just before the 2027 data collection, so preparations for the next OMB PRA process will begin in 2025.

- **Planned Changes for the 2027 QHP Enrollee Survey.** Many of the proposed changes that are under discussion are set to take effect with the 2027 QHP Enrollee Survey. The TEP will have opportunities to provide input on these adjustments in future meetings leading up to the 2027 survey administration.
- **Draft and Final Call Letter Process.** The Draft and Final Call Letter process gathers feedback on the QHP Enrollee Survey and the QRS from interested parties.
- **OMB PRA Package Preparation.** The OMB PRA package timeline includes periods for the required 60-day and 30-day public comment phases when the survey is posted on the Federal Register. These steps ensure compliance with the PRA requirements before CMS implements changes.

### *Addition of New Sample Frame Variables*

- CMS is interested in adding variables to the sample frame to support analyses of response. The sample frame does follow a standard format for several variables that can be used. The variables are typically used in analyses or case-mix adjustment. The items being explored include the following:
  - 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 has a primary care provider.
  - Visit with specialty care doctor—Enrollee had at least one visit with a specialty care doctor during the measurement year.
- These variables will not have completion thresholds, meaning populating them is not required. The new variables are aligned with the National Committee for Quality Assurance's plans for the Healthcare Effectiveness Data and Information Set (HEDIS®[4]) and CAHPS variables.

Ms. Van posed discussion questions to TEP members for additional input.

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Question(s) Posed to the TEP:**
**What are your thoughts on the additional proposed refinements?**

**What do you agree or disagree with?**

**TEP members provided the following feedback on the new potential sample frame variables:**

- A TEP member asked where in the survey these variables would appear. Ms. Van responded that the variables are assigned by the QHP issuers. The issuer would look at their enrollment data and identify whether an enrollee has a primary care provider assigned to them, or if an enrollee has had a claim. This could potentially result in differences between the QHP issuer data and the responses obtained from the enrollee (for example, if a QHP issuer indicates that someone did not have a claim or encounter but the questions that someone responds to do indicate that they have had a claim with the health plan). These new variables will be used in analyses of response patterns and could inform potential case-mix adjustments. The TEP member asked if this is standard information collected by the issuer. Ms. Van noted that ideally an issuer would be able to easily populate these data, for example a QHP issuer would be able to identify if someone has had a claim with them. However, there is no completion threshold set in case the data are difficult to obtain.
- A TEP member inquired whether the plan's methodology would be accepted for assigning a member to a primary care provider. Ms. Van confirmed that the variables will have a broad definition. The variables undergo a HEDIS audit, so there will be a methodology assigned when QHP issuers are pulling the sample frame, but there is no standard methodology that will be set for attributing primary care providers.
- A TEP member asked about the rationale behind the suggested variables. Ms. Van responded that the variables are added to help contextualize the findings from the QHP Enrollee Survey and provide insights into response patterns and survey results. For example, the team would be able to see whether health plan ratings vary by whether an enrollee had a claim with the QHP issuer. Having data from an administrative source would provide the opportunity for improvements, case-mix adjustment, and stratifying measures. The TEP member added that it makes a difference whether enrollees requested a specialty care provider and did or did not get the visit, versus if they were referred to a specialty care provider, as these are potentially very different situations. The TEP member felt that, in their own situation, having a primary care provider did not lead to greater or less satisfaction with their plan, as they have never met their primary care provider (i.e., they received care from other providers in the practice). This affected their satisfaction with the provider more than with the plan.

- A TEP member stated that they do not have any objections to the suggested variables as the variables are easy to answer. The member suggested revising the wording of the questions to specify that the terms apply to the members themselves, and not family members or others that they may have helped. Ms. Van clarified that these were sample frame variables and responded that this was a great suggestion that could be specified in the data dictionary for the sample frame or integrated into the technical guidance.

### *Instrument Revision: Gate Questions for Access to Plan*

- CMS is exploring a global question that asks enrollees how they have used their health plan in the last 6 months rather than collecting this information through individual items. This question could be used to build a skip logic that would reduce the response burden on consumers taking the survey through internet or phone administration modes.

Ms. Van posed discussion questions to TEP members for additional input.

**Question(s) Posed to the TEP:**

**What are your thoughts on the additional proposed refinements?**

**What do you agree or disagree with?**

**TEP members provided the following feedback on the potential gate questions:**

- A TEP member stated that the CAHPS version was much easier for patients and enrollees who are using the internet or telephone version of the survey, as it allows automatic skips, and can shorten the survey. The member acknowledged that the CAHPS version increases the length of the mail survey.
- A TEP member asked if the updated questions would apply to the customer service or urgent care questions. The Project Team answered that if implemented, the questions would match the rest of the CAHPS questions and be implemented across all the questions with non-applicable as a response option. These questions would become skip pattern questions instead. The TEP member found that for the urgent care item especially, a non-applicable response option affects the percentage of people who said they had an urgent visit. Due to this, the member leans toward aligning the questions with the CAHPS 5.1 version. The Project Team added that the questions were shown during focus groups and cognitive testing, and the questions received mixed feedback. However, people were able to follow the skip patterns.
- Regarding the questions related to customer support in the survey instrument, a consumer member shared that the revised structure could be useful when responding to Question 6

of the survey ("In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"). QHP enrollees may not have contact with customer service. The "yes" or "no" options in response to Question 6 could help respondents answer the question more easily, while providing the opportunity to go into more detail if the question is applicable. The member also shared that, due to customer service lines often being overseas, there are cultural differences that may exist between the member and customer service representative. Therefore, the questions that ask about customer service treating a member with respect (Question 7) are up to interpretation and may easily differ among members. In many cases, the "yes" or "no" option is simple and straightforward. The Project Team noted that this supports previous feedback.

### *Instrument Revisions: Align Telehealth Questions With CAHPS 5.1*

- Several questions were revised and added to the QHP Enrollee Survey instrument because of the public health emergency. These questions included adding the clarifying statement "Include in-person, telephone, or video appointments" to the end of select questions in the following sections: 'Your Health Care in the Last 6 Months,' 'Your Personal Doctor,' and 'Getting Health Care from Specialists'." During this revision period, the CAHPS team also revised the CAHPS Health Plan Survey and released version 5.1, which asks about appointments made "in person, by phone, or by video" within the question itself.

Ms. Van posed discussion questions to TEP members for additional input.

**Question(s) Posed to the TEP:**
**What are your thoughts on the additional proposed refinements?**

**What do you agree or disagree with?**

**TEP members provided the following feedback on aligning telehealth questions with CAHPS 5.1:**

- A TEP member agreed with the CAHPS version of this item under the assumption that the questions are cognitively tested. Another TEP member agreed and noted that it is easier for the QHP to align with CAHPS and therefore, they support the change. Several other TEP members approved of the changes with one consumer noting that the CAHPS version is more direct.
- A TEP member asked if the survey includes questions about email communication with providers. The Project Team responded that the survey does not ask about one-on-one communication with providers. The TEP member also pointed out that some surveys ask about telehealth nurses, or alternatives to a traditional visit. The Project Team responded that these questions focus on personal doctors, although people may interpret "personal

doctor" in multiple ways. However, this could be an opportunity for additional survey questions to explore other aspects of health plans that are helpful.

## 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 2025 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 2 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 fall 2025. The team will follow up via email to share updates.

# Appendix A. TEP Members

| QHP Enrollee Survey TEP Attendance: Option Year 2 Meeting #2 | X if attended |
|---|---|
| **Noemi Altman, MPA**<br>Senior Survey Research Associate<br>Consumer Reports, New York, NY | X |
| **Kellan Baker, PhD**<br>Executive Director and Chief Learning Officer<br>Whitman-Walker Institute, Washington, DC | |
| **Steve Butterfield, MA**<br>Director of State Public Policy<br>The Leukemia & Lymphoma Society, Rye Brook, NY | X |
| **Shirley Dominguez**<br>Consumer/Navigator<br>Community Engagement Specialist (Epilepsy Alliance) | X |
| **Blake Hodges, MS**<br>Senior Consultant<br>Kaiser Foundation Health Plan, Denver, CO | X |
| **Itisha Jefferson, BS, Medical Doctorate Candidate**<br>Consumer and Family Caregiver<br>Loyola University, Stritch School of Medicine, Maywood, IL | X |
| **William Lehrman, PhD**<br>Social Science Research Analyst<br>Centers for Medicare & Medicaid Services, Baltimore, MD | X |
| **Paloma Luisi, MPH**<br>Director of the Bureau of Quality Measurement & Evaluation<br>New York State Department of Health, Albany, NY | X |
| **Christine Monahan, JD**<br>Assistant Research Professor<br>Georgetown Center on Health Insurance Reforms, Washington, DC | X |
| **Kimberly Morgan**<br>Director, Quality and Performance Measurement<br>Point32Health | |
| **Erin O'Rourke, BS**<br>Executive Director of Clinical Performance and Transformation<br>America's Health Insurance Plans, Washington, DC | X |

| QHP Enrollee Survey TEP Attendance: Option Year 2 Meeting #2 | X if attended |
|---|---|
| **Keri Setaro, BFA**<br>Consumer; Self-Employed<br>Montclair, NJ | |
| **Ivan Smith**<br>Consumer<br>Landscaper | X |
| **Jennifer Sullivan, MHS**<br>Director of Health Coverage Access<br>Center on Budget and Policy Priorities, Washington, DC | X |
| **Silvia Yee, MA, LLB**<br>Senior Staff Attorney<br>Disability and Rights Education and Defense Fund, Berkeley, CA | X |

# Appendix B. Meeting Attendees

| Centers for Medicare & Medicaid Services (CMS) Attendees |
|---|
| **Ryan Hax, Contracting Officer Representative**<br>Centers for Medicare & Medicaid Services (CMS)<br>Center for Clinical Standards & Quality (CCSQ)<br>Quality Measurement & Value-based Incentives Group (QMVIG) |
| **Melodee Koehler, QHP Enrollee Survey Lead**<br>Centers for Medicare & Medicaid Services (CMS)<br>Center for Clinical Standards & Quality (CCSQ)<br>Quality Measurement & Value-based Incentives Group (QMVIG) |
| **Nidhi Singh-Shah, Deputy Director for Division of Program and Measurement Support**<br>Centers for Medicare & Medicaid Services (CMS)<br>Center for Clinical Standards & Quality (CCSQ)<br>Quality Measurement & Value-based Incentives Group (QMVIG) |
| **Elizabeth Hechtman, Stakeholder Outreach Coordinator**<br>Centers for Medicare & Medicaid Services (CMS)<br>Consumer Information and Insurance Oversight (CCIIO) |

| QHP Enrollee Survey Project Team Attendees |
|---|
| **Coretta Lankford, Project Director and TEP Chair**<br>American Institutes for Research (AIR) |
| **Tandrea Hilliard-Boone, TEP Task Lead**<br>American Institutes for Research (AIR) |
| **Cindy Van, Senior Researcher**<br>American Institutes for Research (AIR) |
| **Chris Evensen, Data Analysis Director**<br>American Institutes for Research (AIR) |
| **Chris Pugliese, Senior Researcher**<br>American Institutes for Research (AIR) |
| **Akua Asante, TEP Coordinator**<br>American Institutes for Research (AIR) |
| **Vanessa Amankwaa, Researcher**<br>American Institutes for Research (AIR) |
| **Zoe Sousane, Project Specialist**<br>American Institutes for Research (AIR) |

| Center for Consumer Information and Insurance Oversight (CCIIO) Marketplace Operations Support Project Team Attendees |
|---|
| **Meshell Hicks, Senior Researcher**<br>American Institutes for Research (AIR) |
| **Jessica Ortiz, Research Associate**<br>American Institutes for Research (AIR) |
| **Amy Bezek, Research Assistant**<br>American Institutes for Research (AIR) |

| Quality Rating System Project Team Attendees |
|---|
| **Melanie Konstant, Lead Associate**<br>Booz Allen Hamilton (BAH) |
| **Suzanne Singer, Associate**<br>Booz Allen Hamilton (BAH) |

# Appendix C. TEP Agenda

## QHP Enrollee Survey TEP Meeting 2

**Friday, February 28, 2025, 2:00–4:00 p.m. Eastern Time (ET)**

**Meeting ID: 978 5712 5076**

**Passcode: +6%gCMzk@f**

**Web Conference URL:**

**https://air-org.zoom.us/j/97857125076?pwd=KB86QtqZf0c7ad7i1r6X9UfKAkBxI3.1**

| Time (EDT) | Topic |
|---|---|
| 2:00–2:35 p.m. | **Welcome and Introductions**<br>• Welcome members and conduct roll call.<br>• Review meeting agenda and objectives.<br>• Review TEP roles and responsibilities.<br>• Recap the previous TEP meeting held on November 4, 2024. |
| 2:35–2:45 p.m. | **Consumers' Reflections**<br>• Hear from consumer TEP members about their experiences with QHPs in the Exchanges. |
| 2:45–2:55 p.m. | **Project Update**<br>• Provide an overview of completed and upcoming activities. |
| 2:55–3:10 p.m. | **Overview of Findings From 2024 QHP Enrollee Survey Analyses**<br>• Review survey data trends and discuss topics to explore in future analyses. |
| 3:10–3:55 p.m. | **Proposed Refinements to the QHP Enrollee Survey**<br>• Discuss the 2025 Draft Call Letter.<br>• Seek feedback from the TEP on proposed refinements to future administrations of the QHP Enrollee Survey. |
| 3:55–4:00 p.m. | **Meeting Wrap-Up**<br>• Review next steps and action items. |

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