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

Deliverable 4-3: Option Year 1 Meeting 2 Summary Report

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Technical Expert Panel Overview

Section 1311(c)(4) of the Patient Protection and Affordable Care Act directs the Secretary of the Department of Health & Human Services (DHHS) 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 2023–2024 TEP consists of 17 stakeholder representatives, including consumers and consumer advocates, Exchange administrators, health plan representatives, quality measurement experts, state officials, and subject matter experts (SMEs). Dr. Coretta Lankford is the project director and TEP chair for the 2023–2024 QHP Enrollee Survey TEP.

Report Purpose

The purpose of the QHP Enrollee Survey Technical Expert Panel (TEP) Meeting Report (Deliverable 4-3) is to summarize the TEP's key takeaways and suggestions for consideration from the Project Team.[3] This report does not include the Project Team's recommendations to CMS based on TEP inputs. The Project Team will formalize its recommendations based on TEP feedback through other deliverables, including the Call Letter for the QRS and QHP Enrollee

[1] 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), 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] All recommendations listed in this report were supported by one or more TEP members.

Survey (Deliverable 4-13), Select Statistical Analyses (Deliverable 8-12), Lessons Learned Report (Deliverable 7-11), and QHP Enrollee Survey Technical Specifications (Deliverable 5-3).

Meeting Summary

The Project Team convened a 1-hour pre-TEP meeting for five TEP members representing consumer perspectives via Zoom® teleconference on Friday, February 2, 2024. Four of the five 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, build upon what was discussed at the third TEP meeting (first TEP meeting of Option Year 1) on October 30, 2023, and allow for new member reflections. The team incorporated summary points from this discussion into the slides for the next TEP meeting.

The Project Team convened the second TEP meeting of the Option Year via Zoom teleconference on Friday, March 1, 2024. Fourteen of the 17 members attended the meeting, including four consumer members. The Project Team sent an email to TEP members after the meeting seeking any additional insights into topics discussed during the meeting.

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

The objectives of the QHP Enrollee Survey TEP meeting were to

- Conduct a roll call, TEP member introductions, and review TEP member responsibilities;
- Recap the recommendations from the October 30, 2023, 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 2023 response analyses,
    - Yearly trends analyses, and
    - Disparities analyses.

Welcome and Roll Call

Ms. Tamika Cowans 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 October 30, 2023, TEP Meeting

Ms. Cowans briefly reviewed discussions from the October 30, 2023, TEP meeting. During that meeting, TEP members and the Project Team introduced themselves. The Project Team recapped the March 2, 2023, TEP meeting and consumer members shared reflections. The Project Team provided updates on the survey project, shared data on survey trends, and gathered TEP member input on potential updates to the survey. A summary of TEP member recommendations from the October 30, 2023, TEP meeting is provided in Exhibit 1. The Project Team expressed gratitude to the TEP for this feedback and noted that they look forward to continued discussions about how CMS can potentially advance these recommendations (Exhibit 1).

Exhibit 1. TEP Member Recommendations From October 30, 2023 Meeting

Topic	Suggestions
Increasing survey participation	• Expand use of QR codes on survey materials. • Produce messaging and advertising to increase trustworthiness around the survey, ensure its legitimacy, and inform enrollees about the forthcoming QHP Enrollee Survey. • Include a government or insurance company logo on the QHP Enrollee Survey to reduce fear of scams and fraud. • Re-examine the importance and redundancy of each survey item to reduce the number of survey questions.
Survey administration	• Email enrollees prior to survey distribution to let respondents know to expect the survey. • Consider administering the QHP Enrollee Survey through enrollee's Healthcare.gov accounts.
Analyses	• Conduct analyses on decreasing composite scores such as "Receiving information in a needed language or format" and "Receiving information about the health plan and cost of care" to assess which languages are necessary for the survey or are not available for respondents.
Perceived unfair treatment question	• Make the perceived unfair treatment question actionable for issuers to use the data and improve upon it. • Provide resources for respondents to report a complaint regarding the perceived unfair treatment question. • Include an "other" response option for perceived unfair treatment questions as a respondent may not know why they were treated unfairly.

Topic	Suggestions
Sexual orientation and gender identity (SOGI) questions	• Assess whether the question regarding sex assigned at birth is essential for the QHP Enrollee Survey and crucial for issuers to have. Similarly, consider the consequences and cost-benefit analysis of including this question.
Primary language question	• Revise the answer choice for the primary language question from "some other language (specify)" to "another language." • Allow the primary language question to have multiple answer choices as some respondents, such as parents, might communicate in a language most comfortable to them but may use English when interacting with their children.

Ms. Cowans then asked TEP members if they had additional comments or reactions to the recap of the last TEP Meeting:

- One TEP member noted their belief that there was additional conversation regarding the SOGI questions and emphasized their importance in the QHP Enrollee Survey. Additionally, they requested clarity on the delayed timeline of implementing the SOGI questions on the survey instrument and inquired whether these questions would be cognitive testing topics or if there are additional plans to strategize on the SOGI questions.
- The Project Team acknowledged the TEP member's concerns and mentioned that there would be further discussion on refinements to the QHP Enrollee Survey later in the meeting. They also explained that the SOGI questions are currently out for public comment as they were included in the Draft 2024 Call Letter for the QRS and QHP Enrollee Survey published by CMS on February 28, 2024. Further, the Project Team described the process for revising the survey instrument as required by the U.S. Office of Management and Budget (OMB)and affirmed ongoing efforts to include SOGI questions in the survey.
- The TEP member thanked the team for its acknowledgment and asked for a link to the Draft 2024 Call Letter. The Project Team shared a link to the publicly posted document in the chat for all TEP members.

Consumers' Reflections on Experiences in the Exchange

Ms. Cowans reviewed key points from the pre-TEP meeting with the four consumer members on February 2, 2024:

- Information about health plan coverage:

  - There is still a need for accurate and timely information on provider network coverage and any change in plan policies such as new prior authorization processes for medication, for example.
  - One consumer noted that changes in coverage over time can be difficult to navigate and suggested that consumer-friendly materials be readily available for enrollees.

- Experiences with care:
  - One consumer described the need for continuity of care once enrolled in a plan. They shared their experience with losing the doctor they enrolled in a plan for as the provider no longer accepted their insurance halfway through the year.
- Agent misrepresentation:
  - A consumer/navigator shared their knowledge of agents accessing consumer's Marketplace accounts and modifying plans without their awareness and expressed the need for this issue to be addressed.
- Inclusive plan coverage:
  - One consumer shared the need for prescription access and health care plans that cover necessary medications, particularly for individuals living with HIV.
  - Another consumer described the need for additional transparency within QHPs surrounding available mental health services and behavioral therapies. They also noted the need for more comprehensive care coverage inclusive of medical, dental, vision, and mental and behavioral services.

Ms. Cowans then asked the four consumer members in attendance if they had additional comments or if others on the TEP had reactions:

- One consumer representative emphasized the need for up-to-date formularies by health plans as they may change after consumers enroll in a plan. The consumer noted this issue is particularly crucial for consumers when they are seeking medication.
- Another TEP consumer representative recalled the discussion consumers had regarding fraud on the Exchange and the ways in which QHPs could allow enrollees to report fraud incidents.
- A TEP member shared that the discussion surrounding fraud resonated with her as she recalled a recent experience she had with a group of Marketplace enrollees, navigators, and other stakeholders in the policy and advocacy community. She described hearing

conversations related to fraud concerns, as well as network coverage and disruptions in continuity of care with provider network participation changes and the frustration this caused for consumers.

- The Project Team acknowledged these concerns and a Project Team member from the Center for Consumer Information and Insurance Oversight (CCIIO) Marketplace Operations Support let consumers know that if they hear additional reports of fraud from consumers or navigators, they should encourage them to report the issues to the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) as it is available 24 hours a day, 7 days a week (except for holidays). The CCIIO team member noted that reporting enables the team to track complaints and understand complaint volume.
- One consumer reiterated a point shared during the pre-TEP meeting regarding school diagnoses for children. They shared that children are being increasingly diagnosed with issues such as attention-deficit/hyperactivity disorder (ADHD). Although schools require these diagnostic tests, most health insurers do not cover these tests.
- A TEP member mentioned that they assume that most health plans, including QHPs, do not cover school-required evaluations. The consumer shared their personal experience with individuals in the armed services for whom these diagnostic services and evaluations are covered, noting that the same services are not covered for their child. They also acknowledged that some public schools provide certain evaluations and services but noted that, if a child attends a private or specialized school, these services may not be covered.
- One TEP member shared that the Individuals with Disabilities Education Act (IDEA) and/or Section 504 require schools that receive federal funds to fund evaluations of students for learning-related disabilities. They further noted that it would be helpful if insurers coordinated with schools to identify who is responsible for providing, funding, and arranging evaluations given that school and insurance contract obligations can overlap when it comes to a child's needs.
- One consumer shared an additional consideration regarding fertility coverage. They noted that it would be helpful to know if plans in the Exchange are considering covering services such as egg preservation or in vitro fertilization. The consumer acknowledged that covering those services may increase plans' prices but they were unsure if any of the health plans within the health care system were moving toward covering these services.

Project Update

Ms. Cindy Van discussed QHP Enrollee Survey project updates, including completed and upcoming activities.

QHP Issuer Activities:

- November 2023: The Project Team released the 2024 Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Operational Instructions and launched the new QHP Website Attestation process.
- November 2023–January 2024: The Project Team collected attestations from QHP issuers on eligibility for the submission of QRS clinical measure data and QHP Enrollee Survey response data.
- May 2024: The Project Team will release the 2025 QRS QHP List to issuers via Health Insurance Oversight System Marketplace Quality Module (HIOS-MQM).

Survey Vendor Recruitment, Approval, and Training:

- September–October 2023: The Project Team completed the 2024 Survey Vendor Training and Approval and released the draft QHP Enrollee Survey Technical Specifications.
- November 2023–April 2024: The Project Team will continue to conduct ongoing quality oversight activities for HHS-approved survey vendors. This includes activities such as material reviews, data record reviews, progress reports, telephone monitoring, and remote site visits.
- January 2024: The Project Team released the Final QHP Enrollee Survey Technical Specifications.
- February 2024: The Project Team hosted 2024 Data Submission Training.

Data Collection Activities:

- February–March 2024: Data collection began for the 2024 QHP Enrollee Survey.
- April 2024: Data submission will be tested with survey vendors.
- April–May 2024: Data collection period ends.
- May 2024: The Project Team will receive the vendors' final data submission and complete data validation

Stakeholder and Public Input:

- February–March 2024: The Project Team will begin conducting cognitive testing of proposed survey revisions with consumers. Additionally, the Project Team will collect feedback on proposed changes to the survey through CMS's Call Letter process.

Ms. Van then asked the TEP members if they had comments or questions on the recent and upcoming activities presented:

- One TEP member inquired about the survey protocol administration, particularly the order of survey mode distribution.
    - The Project Team responded that the survey protocol administration begins with mail and is followed by internet, and then phone.
- A TEP member asked which proposed revisions will undergo cognitive testing.
    - The Project Team explained that the cognitive testing package, which is currently awaiting approval, will test SOGI questions, the perceived unfair treatment question, and some previously included survey questions and instructions. The Project Team noted that testing is scheduled for March and April and findings will be reported at the next TEP meeting.
    - Another TEP member asked whether testing would cover revised items or the entire questionnaire.
        - The Project Team specified that the cognitive testing will focus on revised items and noted that due to time constraints, it is not possible to test the entire survey.
    - Another TEP member requested additional information on materials detailing the cognitive testing process, including question order and expected respondent characteristics.
        - The Project Team noted that these details can be shared offline and highlighted that more information will be provided during the TEP meeting in the fall as the team is still awaiting OMB approval to complete cognitive testing.

Recent and Potential Updates to the QHP Enrollee Survey

Ms. Van shared recent and potential considerations for updating the QHP Enrollee Survey in future administrations.

Prior to discussing recent and potential updates, the Project Team asked the TEP to keep the following considerations in mind:

- CMS is required to secure clearance from OMB for information collection associated with consumer testing efforts. This mandated process, governed by the Paperwork Reduction Act (PRA), aims to
    - Manage the information federal agencies request of the public.
    - Ensure that decisions are grounded in high-quality data.
    - Safeguard private information.
- Refinements to the QHP Enrollee Survey hold implications for the QRS:
    - Survey data informs QRS measures.
    - Survey refinements may not align with other CAHPS surveys, even though the QHP Enrollee Survey draws heavily from the CAHPS Adult Commercial Health Plan survey to facilitate cross-product line comparisons (e.g., Medicare, Medicaid).

The Project Team summarized the most recent updates that were approved in the last OMB package and implemented with the 2024 QHP Enrollee Survey:

- Removed two survey questions (public health emergency and flu vaccination) to shorten the survey and reduce burden.
- Revised race and ethnicity questions with expanded options to align with other CMS-sponsored surveys and CAHPS surveys.
- Obtained OMB approval for the survey instrument through 2026 and updated the OMB statement accordingly on the survey instrument.

The Project Team shared forthcoming revisions that are undergoing public comment:

- Proposal to remove oversampling caps for the 2025 enrollee survey in alignment with other CMS-sponsored surveys.
- Proposal for future year revisions, including potential changes to the survey instrument and protocol:
    - Addition of perceived unfair treatment, SOGI, and primary language questions.
    - Revisions to the mixed-mode data collection methodology (internet prior to sending mail surveys).

The Project Team shared additional changes that are under consideration. They noted that these changes were not included in the Draft 2024 Call Letter and may be included in future outreach efforts:

- Revise QR code guidance for survey vendors in the 2025 QHP Enrollee Survey to make QR code use mandatory rather than optional.
- For future survey administrations, the Project Team is exploring the potential to revise cover letters and emails to be more engaging, friendlier, and less wordy, which is in line with changes made in other CAHPS surveys. Additionally, the Project Team is exploring the potential to extend fielding periods to provide more time for survey completion.

Ms. Van then asked the TEP members if they had comments or questions on the recent and potential updates presented:

- A TEP member inquired about QHP issuers oversampling, specifically whether they had to provide a reason to oversample.
    - The Project Team responded by noting that issuers submit requests for oversampling through their vendors. Vendors submit a list of their clients and the reporting units to the Project Team and include the requested oversampling percentage and reasoning for the oversampling request for each client. The Project Team shared that the most common reason heard from issuers is to receive reportable results and because of that, these requests are typically approved.
- Another TEP member inquired about the minimum and maximum sample sizes issuers can choose and who is required to pay for oversampling.
    - The Project Team explained that the current guidance specifies that the minimum oversampling percentage is 5% (65 enrollees over the 1,300 base sample) and the maximum is 30% (1,690 enrollees over the base sample). Additionally, the Project Team mentioned that oversampling costs are covered by issuers contracting with vendors and authorizing vendors to field the survey on their behalf.
    - The TEP member also asked if the internet and mail survey fielding occur simultaneously.
        - The Project Team answered affirmatively and noted that CMS is considering survey fielding with the internet mode followed by the mail mode for future survey cycles. The Project Team shared that this consideration may allow for potential cost savings and increased response

rates. Additionally, the Project Team expressed interest in receiving public comment on this consideration.

  - The TEP member suggested administering the survey in a sequential mode, starting with internet, and following up with mail in about a week. They shared that this practice will be implemented with the Hospital CAHPS (HCAHPS) survey in January 2025.
    - The TEP member followed up via email to share documents providing information on methodological changes made to the HCAHPS survey based on findings from the 2021 HCAHPS mode experiment.

- One TEP member commended the decision to allow plans to oversample at any desired level and noted that plans prefer conducting data analyses with greater precision and to do so, they need a larger number of completed surveys.
- Another TEP member agreed with the previous point of waiting a week after internet fielding before initiating follow-up with the mail survey. Additionally, they asked whether an enrollee who completed the internet survey would still receive a mail follow-up.
  - The Project Team responded that the enrollee would not receive a mail follow-up and would be removed from the protocol once their completed survey had been received.
  - The TEP member additionally shared insights from their experience with Medicare Advantage and Prescription Drug Plan CAHPS (MA & PDP CAHPS), specifically that CMS allows the submission of an analysis plan ahead of survey fielding to explore additional analyses. They suggested that the Project Team consider this approach moving forward.
  - The Project Team thanked the TEP member for their insights and noted this option would be considered for future survey cycles.

After presenting the proposed revisions to the survey protocol, Ms. Van then posed the following questions to TEP members and asked if they had additional feedback.

Question(s) Posed to the TEP:

- **What feedback do you have on the additional changes that are under consideration?**
- **What additional improvements or changes to survey administration protocols can we make that can help improve response rates?**

TEP members provided the following feedback and recommendations:

- A TEP member shared that they found a significant increase in responses from individuals from racial and ethnic minority groups and younger populations when extending the survey administration period from 42 to 49 days for the HCAHPS mode experiment. Additionally, they recommended that survey cover letters be short and easy to read and that surveys be deployed sequentially beginning with the internet mode.
    - One TEP member shared their support for shortening cover letters and offered additional considerations such as including government or insurance company logos on survey materials, pre-notifying enrollees via email to make them aware of the survey, and incorporating QR codes on survey materials.
    - The Project Team acknowledged these suggestions and stated that changes to the survey protocol and vendor requirements, such as the use of QR codes and the addition of logos, can be implemented in the Technical Specifications document. The Project Team noted that the Final Technical Specifications will be shared with the TEP and will reflect feedback received on survey protocol changes.
- Two TEP members expressed agreement in the chat regarding the removal of oversampling caps.
- One TEP member sought clarification on the survey administration process and asked for confirmation that individuals who do not respond to the internet survey mode would receive subsequent survey modes (mail and phone communications).
    - The Project Team confirmed that is correct and explained that there is a sequential order of survey distribution currently in process.
    - The TEP member also suggested including a broad question that enrollees can answer in the body of the internet email notification for future surveys to improve response rates. Another TEP member noted that this is common practice in product research.
    - The Project Team acknowledged these suggestions and noted that they will be taken into consideration.
- One TEP member recalled previous TEP meeting discussions regarding providing cover letters in an enrollee's preferred language. The TEP member asked if the Project Team received and analyzed these data from sampled health plans as they could spur action.

- The Project Team acknowledged this recommendation and noted that findings from the disparities analyses would be presented later. The Project Team also communicated that the survey is currently available in three languages (English, Spanish, and Chinese). Additionally, the Project Team shared that the language preference flag data come from the issuers and are placed into the sample where the vendors can identify which languages to field the survey in.
- The TEP member also asked who decides on the primary language to field the survey in, the survey vendor or the QHP issuers.
  - The Project Team explained that the QHP issuers work with their survey vendors to determine the best option for fielding the survey in different languages. Survey vendors can field the survey in Spanish first using the language preference flag or vendors can double stuff their survey materials with English and Spanish or English and Chinese, as necessary. Ultimately, it is up to the vendor and QHP issuer to decide on which method works best for them.

Overview of Findings From Select Statistical Analyses

Ms. Brittany Martin, statistician and SAS programmer, and Mr. Christian Evensen, Data Analysis Director, provided an overview of survey response, trend, and disparities analyses from 2023 QHP Enrollee Survey data.

Survey Response Analysis

The survey response analysis was conducted to estimate differences between respondents and nonrespondents on survey variables of interest such as survey vendor and oversampling flags, enrollee characteristics (sex, age, language preference, and census region), and plan characteristics (metal level and product type). The main outcome of interest for the response analysis was response rate, which was calculated using the American Association of Public Opinion Research's (AAPOR) "response rate 3" (RR3)" formula.[4]

- Overall results.
  - *Sample Frame*: In 2023, 324 reporting units (RUs) fielded the QHP Enrollee Survey, sampling a total of 447,851 enrollees. The total sample for 2023 QHP survey administration showed a substantial increase of 46,792 enrollees from the 2022 survey.

[4] The American Association for Public Opinion Research. (2016*). Standard definitions: Final dispositions of case codes and outcome rates for surveys* (9th ed.).

- *Oversampling*: This year, there was also an increase in the number of RUs who chose to oversample: 158 RUs oversampled in 2023, which is an 8% increase compared to the 2022 QHP survey administration; 108 of the 158 RUs that oversampled did so at the maximum rate allowed, 30%.
- *Response rate:* The overall response rate for the 2023 QHP Enrollee Survey was 16.3%; the overall response rate for the 2022 administration was 18.3%.
- *Likelihood of response:* Multivariable analysis showed a higher probability to respond among women, older enrollees, enrollees in the upper Midwest, and those with a higher metal level.

- **Nonresponse Bias.** The Project Team monitors for the potential of nonresponse bias yearly. Nonresponse bias can become a problem when the probability of completing a survey is correlated with enrollee or plan characteristics, and when survey scores differ by those specific enrollee or plan characteristics. The Project Team conducted a nonresponse bias analysis and found:
  - The differences in overall ratings were statistically significant by enrollee gender, age, census region, and plan metal level and plan product type.
  - Differences by age and metal level were larger (e.g., bronze plans are generally rated lower than gold plans with an average rating of 64.7 compared to 70.9, respectively).
  - Differences by gender, product type, and census region were smaller (e.g., female respondents generally reported more favorable responses to their plans than male respondents with an average rating of 70.9 compared to 60.9, respectively).
  - While scores had larger differences among metal levels, the difference in the probability of response between metal levels was small, indicating that bias may not be an issue for metal level.

Ms. Martin posed a discussion question to TEP members for additional input.

Question(s) Posed to the TEP:
More surveys are being completed every year by [cell] phone compared to PC. How can we improve survey administration in light of this fact?

TEP members provided the following feedback and recommendations on improving survey administration:

- One TEP member inquired if it was an issue if a respondent completed the survey using their cell phone rather than using a personal computer (PC).
    - The Project Team shared that it is not an issue from a data perspective, but the team is thinking of how to get better response rates as people are increasingly using their phones. The team shared that they would like to get more data, for example, regarding which web design works better on a phone versus what a respondent might see when they open the survey on their computers.
    - The TEP member also asked if enrollees completing the survey using their phones are immediately directed to the survey or must go through a website to go to the survey. The TEP member also noted that their best advice is to make sure that the survey is optimized for use on any device.
    - The Project Team shared that enrollees are instantly directed to the survey and noted that the survey is optimized for use on several devices as the Project Team tests this thoroughly before survey fielding.
- Another TEP member asked if the Project Team analyzed the completion rate, particularly to see if respondents were skipping questions or stopping the survey at a certain point and whether that was higher for people on mobile devices versus PCs.
    - The Project Team responded they were unsure whether the data had been split to observe the differences between respondents completing the web survey via phone or by PC, but they would consider this suggestion.
    - An additional TEP member expressed their interest in examining drop rate data for those completing the survey via cell phone versus PC.
- One TEP member also commented on the optimization of the QHP Enrollee Survey for mobile devices and noted that the survey must be accessible for those who are blind, have mobility disabilities, and beyond.
    - The Project Team acknowledged this point and noted that the team does consider accessibility as part of optimization.
- One TEP member shared that respondents' paradata might give insights into how long respondents spent on a question or the entire survey.
    - The Project Team noted that there are certain data points available such as the last question completed before drop off, the length of time to complete the survey (for telephone and internet only), and the completion mode. The

Project Team has not yet completed analysis of completion time between those who complete the internet survey via phone or PC.

- Another TEP member asked if respondents who begin answering the survey over the phone and are unable to complete it or get interrupted, for example, can go back to where they stopped in the survey and/or use another survey administration mode to complete it.
    - The Project Team shared that, regarding the internet survey, respondents are allowed to pick up from where they left off but if they choose to use a different mode, vendors are required to have the respondent start the survey again entirely. The Project Team explained that this is because there are differences in how some questions are asked depending on the survey mode (mail, internet, or phone). Additionally, the Project Team shared that when the vendors submit the survey data to the team, they submit the mode that is the most complete in survey progress as opposed to the mode the enrollee started first; this ensures that there is no bias across the different survey modes.
    - The TEP member spoke to the potential of a respondent encountering difficulties completing the survey due to their disabilities and, as a result, requests that they be able to complete the survey via phone.
        - The Project Team acknowledged this point and shared that the survey vendors are required to include customer service information on the survey materials so that respondents can request the assistance they might need.
- Additionally, one TEP member asked if the QHP Enrollee Survey allowed for proxies to complete the survey and if there were any questions about proxies on the survey.
    - The Project Team shared that proxies are allowed to complete the survey and the final question of the QHP Enrollee Survey captures data on how the proxy assisted the respondent in completing the survey.
    - The TEP member applauded proxies being allowed to complete the survey for a respondent and noted that the team should explore analyses assessing potential systematic differences between how a proxy responds to the survey as opposed to the respondent. The TEP member shared that proxy questions were removed from the HCAHPS survey, as they did not adjust for it in analyses. They also noted that the HCAHPS survey will allow for proxies in the future but will not be adjusted by whether the proxy or patient completed the survey.

Yearly Trend Analysis

To investigate survey trends over the years, the Project Team conducted analyses assessing differences in survey response trends by survey mode and distribution of survey scores.

- **Response Rates and Propensity to Respond.** Overall response rates calculated based on RR3 have declined over the last 6 years, from 27% in 2017 to 16% in 2023. Similarly, the propensity to respond has declined from 19% in 2017 to 12% in 2023.
    - **By Age.** When assessing response rates and trends by age, analyses displayed variation by age cohort. For example, older enrollees have higher response rates than younger enrollees; however, the downward trend in response rates over time is consistent across those age groups.
    - **By Unknown Eligibility.** For the 2023 response rate, the percentage of sampled QHP enrollees for whom survey eligibility cannot be confirmed, otherwise classified as "unknown eligibility," has continued to increase steadily each year (67% in 2017 to 81% in 2023). The inability to confirm an enrollee's eligibility is primarily a result of nonresponse after an individual has not responded after the nine maximum allotted attempts. This trend is likely explained by a combination of the quality of contact information and a trend of increasing hesitancy among the population to respond to unsolicited mail, phone calls, or emails.
        - **By Unknown Eligibility by Age.** The trends in predicted eligibility are parallel by age cohort and eligibility has steadily risen each year across all age groups, but the rates vary by age. The predicted probability of having a disposition of unknown eligibility was over 80% for the four youngest cohorts (ages 18–54) in 2023, while the lowest predicted probability (71%) was for those aged 55–64. These trends have been seen in surveys across health care-related areas and beyond, such as those conducted by the Bureau of Labor Statistics (BLS).
- **Share of Completes by Survey Mode.** Like the 2022 QHP Enrollee Survey data, the Project Team found that mail surveys continue to account for the plurality of survey completes at 48%, followed by internet at 35%, and phone at 17%. Additionally, the effort to shift the share of completes from mail and phone toward internet has been successful as it has leveled over the last 3 years from 33% in 2021 to 34% in 2023. Among enrollees completing the survey via internet, the Project Team found that mobile phones accounted for the largest number of completed surveys at 51%, almost a 4% increase from 2022.

- **Respondent Characteristics Associated with Survey Mode Response.** The share of responses by mode of completion varied by respondent characteristics. The Project Team found that the data below exemplifies the importance of other modes for obtaining completed surveys from a diverse population of enrollees.
    - **By age.** Individuals ages 35 and older were less likely to complete the survey by phone or internet compared to mail, while younger individuals (ages 18–35) were more likely to complete it by phone or internet than by mail.
    - **By education.** Compared to mail, the Project Team found that enrollees with more education were less likely to complete the survey by phone and more likely to complete the survey by internet.
    - **By race/ethnicity.** Those who identified as Black, Asian, or more than one race and those with race data missing were more likely to complete the survey by phone than by mail, while those identifying as Native Hawaiian or Other Pacific Islander (NHPI) were less likely to complete the survey by phone compared to mail.
        - **Survey Mode.** The likelihood of choosing the internet mode over mail varied across race. Those who identified as Asian or Black were more likely than White enrollees to complete the survey by internet versus mail, while those with missing race data or who selected more than one race were less likely than White enrollees to complete the survey by internet versus by mail.
- **Survey Composite Scores.** Over the last 6 years, respondents have consistently rated QHP performance in the following areas highly: measures of clinician behavior (e.g., doctor communication, care coordination, and overall ratings of doctors and specialists), overall ratings of health plan and health care, and enrollee experience with cost. The average scores for these measures have remained in the 80s on a 100-point scale. The outliers for these measures both over- and underperform relative to the mean.

  Measures that have shown either consistently lower performance, declining performance over time, or both include QHP performance regarding consumers' ability to find relevant information about their plans, their experiences with customer service, and access to care composites (getting needed care and getting care quickly). Potential outlier RUs tend to underperform relative to the average RU and tend to have scores far below the mean.

There has been an especially large variation in the QHPs performance regarding the "getting needed care" measure, which ranges around 35 points from the lowest to highest performing QHP.

Mr. Evensen posed the following discussion questions to TEP members for additional input.

Question(s) Posed to the TEP:

- **Do you have any advice about strategies to improve the quality of contact information provided by issuers?**
- **Do you have any advice about how to improve the way we contact sampled enrollees that would make them less hesitant to respond?**
- **How can we better highlight areas of poor performance in the QI reports?**

TEP members provided the following feedback for consideration:

- One TEP member asked if there had been an analysis conducted correlating the extreme outlier responses between 2019 and 2022 with the impact of COVID-19 and use of telehealth.
  - The Project Team responded that there have not been analyses conducted on COVID-19 and telehealth at this point but noted that the prominent dip in scores between 2019 and 2021 was related to changes made to the survey that resulted in an increase in negative responses.
- Another TEP member inquired how the Project Team receives contact information for the enrollees.
  - The Project Team shared that the vendors receive enrollees' contact information from QHP issuers through the sample frame. Additionally, the Project Team shared that there are established processes and requirements in place to ensure that issuers receive the best contact information for their enrollees.
  - The TEP member acknowledged the importance of valid contact information and noted that, in their own experience, they have found a large difference between those with a valid email address and those who do not have a valid email address or do not provide one. They also noted some hospitals are better at collecting email information than others.
  - The Project Team shared that 53% of sampled enrollees are missing data on language preference and 46% are missing data on their spoken language

preference. The Project Team communicated that many issuers are unable to collect this information so ultimately, there is no way to know what an enrollee's language preference is until they respond to the survey.

  - The TEP member inquired about processes in place to ensure that issuers can get the contact information they need.
  - The Project Team shared that there are established procedures and requirements in place and described telematching, as an example, where issuers are required to look for additional phone numbers especially if they do not have a valid phone number from the sample frame. Additionally, there are quality checks in place and Healthcare Effectiveness Data and Information Set (HEDIS) audit reviews where QHP issuers must meet completeness thresholds recommended in the sample frame. For example, the Project Team shared that the language preference flag threshold is 50%, meaning issuers must provide at least 50% of the data for their enrollees as part of the audit process. If this information is unavailable, the Project Team then depends on the survey vendor to obtain it.
  - Additionally, the TEP member suggested that we ask individuals the reasons they might be hesitant to complete the survey during cognitive interviews.
  - The Project Team noted that consumers who participated in the previously conducted focus groups were asked what would make the survey more trustworthy and what would make it more likely for them to respond. Consumers shared examples of not knowing where a survey is coming from and the rise of scams making them less likely to respond but did not speak specifically to the QHP Enrollee Survey as they had not heard of it or ever received it.

- Another TEP member shared that they were curious to know, among those individuals who have completed the survey, how many of them know what the survey is used for, its purpose, and the overall value in participating. They shared that even if individuals do trust the survey and believe it to be legitimate, they still might decide it is not worth their time to complete the survey because they are unsure where the information is going and ultimately, why it matters. The TEP member spoke to their individual experience working with consumers and noted that their organization has become increasingly more purposeful in the reasons why they are asking consumers for their time, recognizing their time as being valuable, and making sure there are properly compensated regarding focus groups or other long-term engagements, for example. Additionally, the TEP member noted that CMS should think about the enrollee's

experience, particularly how the survey is valuable to them and what can be done to show how the survey data are being used and demonstrate the utility of people sharing their experiences and giving their time.

  - The Project Team acknowledged the points shared and noted that the survey cover letters state the reasons why an individual is being asked to take the survey. However, there may be an opportunity to further communicate the importance of the survey.
  - Another TEP member agreed with the points shared and suggested that an explanation on the importance of the survey can come from more trusted sources in the community. They shared, for example, for different languages and racial/ethnic groups, there could be an educational campaign to educate people on why we want and need their responses for the survey, which they noted is ultimately to improve the product.

- A TEP member shared that the CMS logo on the mail cover letters adds more credibility to the survey. Additionally, the TEP member asked if there have been any analyses conducted to see if the response rate data are substantially different for newer enrollees versus older ones as this might account for differences in the response rate. They shared their personal experience with previous work where they noticed that individuals with interactions with health care providers were more likely to complete a survey than those who were newer to a plan and were less likely to have had a visit. Similarly, the TEP member expressed uncertainty regarding whether response rates for those who have only had remote care are substantially different from those with in-person care and if that too can account for the differences in response rates.
  - The Project Team acknowledged the points raised regarding differences in response rates and noted that these data are not available.
  - The TEP member shared that the health plans would have these data and asked if the Project Team has reached out to the health plans for supplemental data.
    - The Project Team responded that this approach could be considered for the future.

Disparities Analysis

The disparities analysis was conducted to examine how survey outcomes differed based on population, particularly race, ethnicity, gender, employment status, disability status, and health insurance literacy.

Disparities in Performance on Select Measures

The Project Team examined 15 outcomes on the survey on a 100-point scale to assess potential disparities in patient care. These outcomes included the global ratings of health plan, health care, primary care provider, and specialist; each of the composite measures (e.g., enrollee's experience with cost); and the single item measures. To conduct these analyses, the Project Team fit an ordinary least squares (OLS) regression model that controlled for case-mix adjusters, number of health care visits, and clustering of data in reporting units. The case-mix variables included general health and mental health ratings, chronic conditions and medications, age, education, survey language, help with survey, and survey mode.

Potential Disparities by Race and Ethnicity

Overall, the Project Team found that Asian and NHPI respondents reported substantially lower outcomes scores than White respondents. Asian respondents had significantly lower scores for nine out of 15 outcomes, while NHPI respondents had lower scores for five out of 15 outcomes. Comparatively, respondents identifying as Black, American Indian, or Alaska Native, and multi-racial only had one or no outcomes with significantly lower scores than White respondents. Hispanic respondents, compared to non-Hispanic respondents, had slightly higher scores for nine of the 15 outcomes. The consistently lower and higher scores found for certain populations may be due to cultural differences, including differences in the prevalence of extreme response tendency (i.e., the tendency to choose the most positive or negative response option available).[5]

The consistent finding from these analyses is that respondents across racial and ethnic minority groups reported statistically significant and substantially lower scores on the measures regarding access to information in a needed language or format compared to White or non-Hispanic respondents. These findings suggest that issuers may not be effectively helping enrollees from racial and ethnic minority groups to receive relevant information about plans in their primary language.

Additional Factors

When assessing differences in outcomes by gender and employment status, the Project Team found negligible differences. On the other hand, individuals who were blind or had serious difficulty seeing had scores that were, on average, 9 points lower for the "receiving information in a needed language or format" measure. This finding suggests that enrollees who are blind or

[5] Mayer, L. A., Elliott, M. N., Haas, A., Hays, R. D., & Weinick, R. M. (2016). Less use of extreme response options by Asians to standardized care scenarios may explain some racial/ethnic differences in CAHPS scores. *Medical Care*, *54*(1), 38–44. https://journals.lww.com/lww-medicalcare/abstract/2016/01000/less_use_of_extreme_response_options_by_asians_to.8.aspx

experience low vision may benefit from concerted efforts by issuers to provide them with information in an accessible format.

Potential Disparities by Health Insurance Literacy

As health insurance and its terminology can be complex, the Project Team acknowledged the importance of examining health insurance literacy on enrollees' experiences.

The data demonstrated that enrollees who were not at all confident in using health insurance scored 13 out of 15 outcomes substantially lower compared to those who were very confident. Similarly, enrollees who were not at all confident in understanding health insurance terms had substantially lower scores for 14 out of 15 outcomes compared to those who were very confident in their understanding.

Overall, the Project Team found that enrollees who do not feel confident using insurance and who do not understand health insurance terminology report substantially lower rated experiences with their health plans. The differences in outcomes scored, on average, 18–22 points lower for measures including rating of health plan, getting information about health plan and cost of care, health plan customer service, forms being easy to fill out, and forms explained by the health plan. These differences remained substantial for other measures more directly related to experience of care as well such as rating of health care, getting care quickly, and getting needed care.

Ms. Martin posed the following discussion questions to TEP members for additional input.

Question(s) Posed to the TEP:

- **How can we best use this information to help enrollees get plan information in a needed language or format?**
- **How can issuers use the finding that low health insurance literacy is associated with 10- to 20-point lower scores to improve plan performance?**

TEP members provided the following feedback for consideration:

- One TEP member asked if the Project Team can give specific feedback to providers—for example, if a provider learns that they are receiving low scores among a particular population, they can plan solution-oriented actions for that audience such as making sure an interpreter is available or increase materials in a necessary language.
    - The Project Team shared that issuers are provided with Quality Improvement (QI) reports, but they do not include that level of specific detail as we are limited in our scope for reporting. The Project Team noted that this feedback

can be further investigated and potentially considered within the QI Report framework.

  - Another TEP member agreed with the above feedback and shared that the areas for QI are a small segment of the population with a small sample size (e.g., people with low vision) but because the Project Team is assessing data at the national level, there may be an opportunity to communicate this information to health plans and allow it to be made actionable. The TEP member also noted that a white paper on key disparities in performance could be helpful and added that the Project Team could leverage vendors as they prepare reports for many of their reporting units.

- A TEP member asked if the Project Team receives information about how many enrollees in a health plan need another language or alternate format for materials.
  - The Project Team shared that information regarding preferred written and spoken language is collected for survey administration. Additionally, the survey asks how often forms that enrollees had to fill out were available in the languages they prefer and if forms were available in the necessary format, but it does not allow for specifics regarding language or format.
  - The TEP member shared that, if they were cynical, they would believe that this information could be actionable in one of two ways—the first being by improving outreach and providing information on alternative formats and languages and the other by decreasing the number of the people in the plan who need this assistance. Additionally, they noted that this disparity is experienced by those who are English language learners or people with vision disabilities, for example, and there are ways to improve their experience. One way is to find and point to the work of disability advocates in the health care field to improve the ways enrollees receive plan information. The TEP member noted that this can be done with data and can be as simple as tracking the needs of enrollees in an electronic record so individuals can consistently have their needs met.

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 for the 2024 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
- Sharing a summary of the TEP meeting once it is posted on the CMS' Measures Management System site.

The Project Team also shared that the next TEP meeting will occur in fall 2024 and that the team would follow up via email to confirm interest in continued TEP participation, collect updated TEP nomination forms and disclosures, and share updates.

Appendix A. TEP Members

QHP Enrollee Survey TEP Attendance: Option Year 1 Meeting #2	X if Attended
Noemi Altman, MPA Senior Survey Research Associate Consumer Reports, New York, NY	X
Tamara Ayala, LPN Consumer	
Kellan Baker, PhD Executive Director and Chief Learning Officer Whitman-Walker Institute, Washington, DC	X
Steve Butterfield, MA Director of State Public Policy The Leukemia & Lymphoma Society, Rye Brook, NY	
Shirley Dominguez Consumer/Navigator Community Engagement Specialist (Epilepsy Alliance)	X
Blake Hodges, MS Senior Consultant Kaiser Foundation Health Plan, Denver, CO	X
Itisha Jefferson, BS Medical student, Consumer and Family Caregiver Loyola University, Stritch School of Medicine, Maywood, IL	X
William Lehrman, PhD Social Science Research Analyst Centers for Medicare & Medicaid Services, Baltimore, MD	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	
Kimberly Morgan Director, Quality and Performance Measurement Point32Health	X

QHP Enrollee Survey TEP Attendance: Option Year 1 Meeting #2	X if Attended
Erin O'Rourke, BS Executive Director of Clinical Performance and Transformation America's Health Insurance Plans, Washington, DC	X
Carl Serrato, PhD Independent Consultant Health Policy and Consumer Rights, Burlingame, CA	X
Keri Setaro, BFA Consumer; Self-Employed Montclair, NJ	X
Donté Smith, Consumer/Navigator and Technical Assistance Associate National Alliance of States & Territorial AIDS Directors	X
Jennifer Sullivan, MHS Director of Health Coverage Access Center on Budget and Policy Priorities, Washington, DC	X
Silvia Yee, MA, LLB Senior Staff Attorney Disability and Rights Education and Defense Fund, Berkeley, CA	X

Appendix B. Additional TEP Meeting Attendees

Centers for Medicare & Medicaid Services (CMS)	X if Attended
Nina Heggs, Contracting Officer Representative Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ) Quality Measurement & Value-Based Incentives Group (QMVIG)	
Preeti Hans, Health Insurance Specialist Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ) Quality Measurement & Value-Based Incentives Group (QMVIG)	
Elizabeth Hechtman, Stakeholder Outreach Coordinator Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO)	X
Kimberly Rawlings Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ)	X
Angela Wright Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ)	
Rebecca Zimmerman, Health Insurance Specialist Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO)	X
Marsha Smith Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ)	X
Mei Zhang Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards & Quality (CCSQ)	X

QHP Enrollee Survey Project Team	X if Attended
Coretta Lankford, Project Director and TEP Chair American Institutes for Research (AIR)	
Tandrea Hilliard-Boone American Institutes for Research (AIR)	

QHP Enrollee Survey Project Team	X if Attended
Tamika Cowans, Senior Researcher, Focus Group & Cognitive Testing Lead American Institutes for Research (AIR)	X
Cindy Van, Senior Researcher American Institutes for Research (AIR)	X
Chris Evensen, Technical Lead American Institutes for Research (AIR)	X
Brittany Martin, Researcher American Institutes for Research (AIR)	X
Akua Asante, TEP Coordinator American Institutes for Research (AIR)	X
Vanessa Amankwaa, Research Associate American Institutes for Research (AIR)	X
Rachel Shapiro, Senior Researcher American Institutes for Research (AIR)	X
Zoe Sousane, Project Specialist American Institutes for Research (AIR)	X

Center for Consumer Information and Insurance Oversight (CCIIO) Marketplace Operations Support Project Team	X if Attended
Melissa Altschiller, Research Associate American Institutes for Research (AIR)	X
Meshell Hicks, Senior Researcher American Institutes for Research (AIR)	X
Heleana Lally, Data Analyst I American Institutes for Research (AIR)	X

Quality Rating System Project Team	X if Attended
Emma Dreher, Associate Booz Allen Hamilton (BAH)	X
Melanie Konstant, Associate Booz Allen Hamilton (BAH)	X

Appendix C. TEP Agenda

QHP Enrollee Survey TEP Meeting 2

Friday, March 1, 2024; 3:00-5:00 p.m. Eastern Time (ET)
Meeting ID: 935 4508 1870
Passcode: s5jb*4HwAN
Web Conference URL:
https://air-org.zoom.us/j/93545081870?pwd=MEtUT2g0MlM0WEdIQWFVcDNZODMzQT09

Time (EDT)	Topic
3:00–3:35 p.m.	**Welcome and Introductions** Welcome members and conduct roll call. Review meeting agenda and objectives. Recap of the previous TEP meeting held on October 30, 2023.
3:35–3:45 p.m.	**Consumer Reflections** Consumer TEP members share their experiences with QHPs in the Exchanges.
3:45–4:00 p.m.	**Project Update** Provide an overview of completed and upcoming activities.
4:00–4:05 p.m.	**5-minute break**
4:05–4:20 p.m.	**Recent and Potential Updates to the QHP Enrollee Survey** Discuss plans for upcoming cognitive testing interviews and seek feedback/recommendations from the TEP on potential updates to the QHP Enrollee Survey.
4:20–4:50 p.m.	**Overview of Findings From Select Statistical Analyses** Review survey data trends and discuss topics to explore in future analyses.
4:50–5:00 p.m.	**Meeting Wrap-Up** Review next steps and action items.

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