SUPPORTING STATEMENT

Part A

Medical Expenditure Panel Survey – Household and Medical Provider Components

Version: February 20, 2026

Agency for Healthcare Research and Quality (AHRQ)

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A. Justification

1. Circumstances that make the collection of information necessary

About AHRQ:
The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see https://www.ahrq.gov/policymakers/hrqa99a.html), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

1. research that develops and presents scientific evidence regarding all aspects of health care; and

2. the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

3. initiatives to advance private and public efforts to improve health care quality.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

Summary of this Information Collection Request (ICR):
This Information Collection Request (ICR) is for a revision to the Medical Expenditure Panel Survey – Household Component (MEPS-HC). These changes will be fielded in the Fall of 2026 and include making minor changes to questions in both the Core MEPS Interview and the Preventive Care Self-Administered Questionnaire (PSAQ) and removing the Burdens and Economic Impacts of Medical Care SAQ (ESAQ) and the Diabetes Care Survey (DCS). These changes are discussed in detail starting on page 8. The OMB Control Number for the MEPS-HC is 0935-0118 and the expiration date is 9/30/2026. AHRQ requests a new expiration date, three years from approval of this ICR.

Project overview:
The Medical Expenditure Panel Survey, which began in 1996, is a set of large-scale surveys of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.), and employers across the United States. MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. The Medical Expenditure

Panel Survey (MEPS) data have become the linchpin for economic health care use and expenditures models. These data are vital in estimating the impact of changes in financing, coverage, and reimbursement policy on the U.S. healthcare system. No other survey provides the foundation for estimating the impact of changes in national policy on various segments of the US population. These data continue to be essential for evaluating healthcare reform policies and analyzing the effect of tax code changes on healthcare expenditures and tax revenue.

The MEPS program is driven by the following statutory language:

Title 42§299b–2. Information on quality and cost of care
(a) In general
The Director shall—
conduct a survey to collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2001 and subsequent fiscal years, quality of health care, including the types of health care services Americans use, their access to health care services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population including rural residents and also for populations identified in section 299(c) of this title; and

Consistent with this language, the main goals of the MEPS program are:
1) To produce nationally representative data estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian noninstitutionalized population.
2) To produce nationally representative data estimates of respondents' health status, demographic and socio-economic characteristics, access to care, and satisfaction with health care.

The MEPS is designed to answer a very wide range of research questions. These include:

1) How do changes in federal and state health policies change health insurance coverage, health care use and expenditures, access to care, patient experiences and satisfaction with their care? Specific policies studies include various Medicaid reforms, the SCHIP program, and state health insurance coverage mandates.
2) How have health care use and expenditures changed over time?
3) What chronic health conditions and other factors drive increases in health care expenditures?
4) How concentrated are health expenditures in the population and how are they distributed? What are the implications for high-deductible health plans, health savings accounts, and other innovations?
5) What is the treated prevalence of childhood conditions (e.g., autism, ADHD, and asthma) and how do these conditions affect health care use and spending?
6) Who uses telehealth and for which types of care?
7) What is the magnitude of the implicit tax subsidy for employer-sponsored health insurance coverage?

8) What is the distribution of out-of-pocket health spending in the population and who has high out-of-pocket burdens?
9) What medications drive changes in prescription drug spending and who pays for these drugs?
10) What is the extent of potentially inappropriate medication prescribing? Which medications (e.g. opioids, antibiotics)? Which populations are at risk?
11) How many Americans switch health insurance coverage during the year (including spells of uninsurance) and what are the implications for health care use and spending?
12) What are patient satisfaction and experiences with their health care and how do they vary across the American population (Adult Self-Administered Questionnaire)?
13) What proportion of the population receives recommended preventive services, how is that distributed, and how do health policy changes impact preventive care use? (Adult Preventive Care Self-Administered Questionnaire)?
14) What is the relationship between diet, exercise, and other health behaviors and health outcomes, healthcare use, and healthcare expenditures? (2026 Adult Preventive Care Self-Administered Questionnaire)?

To achieve the goals of this project the following data collections will be implemented and are currently approved by OMB:

Household Component – The MEPS-HC collects data from a sample of families and individuals in communities across the United States, drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey (conducted by the National Center for Health Statistics). Each year, the MEPS selects a new household sample, and those individuals are followed for two years. Therefore, the entire annual MEPS household sample typically consists of two overlapping panels. The MEPS-HC consists of a core interview administered to all sampled households, supplemental interviews administered to selected individuals, permission forms and a validation interview:

1) **Core MEPS-HC Interview** – All sampled households are administered the Core MEPS interview which collects health, health insurance, and employment data on all household members. All data for a sampled household are typically reported by a single household respondent. During the interview individual household members are identified to complete a self-administered questionnaire. The interview also determines which permission forms need to be signed. The MEPS-HC Core Interview questions are included in Attachments 1 to 47 and interviewer showcards used during the interview are in Attachment 48.

2) **Adult Self-Administered Questionnaire (Adult SAQ)** – Completed by all adults 18 and older in the household in rounds 2 and 4 in odd years. Collects a variety of health status and health care quality measures of adults age 18 and older. The SAQ contains three measures of health status: the Veteran's RAND 12-item (VR-12), the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ-2). The health care quality measures in the SAQ were

taken from the health plan version of CAHPS®, an AHRQ-sponsored family of survey instruments designed to measure quality of care from the consumer's perspective. The Adult SAQ is in Attachment 49.

3) **Preventive Care Self-Administered Questionnaire (PSAQ)** - Designed to collect a variety of person-level preventive health care data for adults. It is distributed to all eligible adults 18 years and older in rounds 2 and 4 in even years. In addition to questions about preventive care, the PSAQ also includes supplemental items on alcohol use, tobacco use, sleep, diet, and exercise. The PSAQ is in Attachment 50.

4) **Authorization Forms for the MEPS-MPC Provider and Pharmacy Survey** – Household members provide authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies. The forms are in Attachments 51 and 52.

5) **MEPS Validation Interview** - Each interviewer is required to have at least 15 percent of his/her caseload validated to ensure that Core questionnaire content was asked appropriately and procedures followed, for example the use of show cards. In excess of this requirement, 100% of MEPS completes undergo validation efforts. Over 50% of cases are validated through the use of Westat's Eagle system which tracks GPS coordinates, matching them to respondent addresses and interview times. Computer Assisted Recorded Interview (CARI) review accounts for roughly 40% of MEPS case validation where EAGLE is not appropriate (computer assisted video interviewing (CAVI) interviews) or is not valid or available. The audio and screen capture from numerous questions is evaluated to ensure an interviewer and a respondent follow proper question administration and show card usage. For cases that cannot be validated using CARI or GPS, phone validations are conduced to ensure proper procedures and administration. Mail validations are used as a final measure when other types of validation have not resulted in a validated case.

   Home office and field management may also request that other cases be validated using any of the aforementioned methods throughout the field period. When an interviewer fails a validation all their work is subject to 100 percent telephone validation. Additionally, any case completed in less than 30 minutes is telephone validated. See Attachments 53a and 53b.

Medical Provider Component - The MEPS-MPC is a survey of medical providers, including office-based doctors, hospitals, home health care providers, and pharmacies, that collects detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. This component of MEPS is necessary because households often cannot accurately report payments made on their behalf for their medical care. Upon completion of the household interview and obtaining permission from the household survey respondents, a sample of medical providers and pharmacies are contacted by telephone to obtain information that household respondents cannot accurately provide. The MPC collects information on dates of visits, diagnosis and

procedure codes, charges and payments, and for pharmacies: dates of fills, ndc (or drug name, strength, dosage), quantity and days supplied, and payments. The MPC is not designed to yield national estimates. It is primarily used as an imputation source to supplement/replace household reported expenditure information. This ICR does not include any changes to the MPC. The MPC includes data collections for specific types of health care providers, outlined below:

1) **MPC Contact Guide/Screening Call.** An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS-MPC, the appropriate MEPS-MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of the seven provider types in the MEPS-MPC, except for the two home care provider types which use the same screening form. The Contact Guide is in Attachment 54.

2) **Home Health Care Providers Event Form** – The MPC collects data from different types of home health care providers. This includes: 1) **home health care agencies** that provide medical care services to household respondents. Information collected with this type of home health care provider includes types of personnel providing the care, hours or visits provided per month, and the charges and payments for services received and 2) **home care for non-health care providers** that focuses on collecting information about services provided in the respondent's home by non-health care workers because of a medical condition (e.g., cleaning or yard work; transportation; shopping; or childcare). The forms are included in Attachments 55 and 56.

3) **Office-Based Providers Event Form –** The MPC collects data from office-based physicians, including Doctor of Medicine (MDs) and osteopathy (Dos), as well as providers practicing under the care or supervision of an MD or DO (e.g., physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff/group model HMOs are included. The information collected includes date of the visit, time spent with the provider, types of treatment and services received, types of medicine prescribed, expenditures, and sources of payment associated with the visit. The form is in Attachment 57.

4) **Separately Billing Doctors Event Form –** The MPC collects information from physicians identified by hospitals as providing care to household respondents during the course of an inpatient, outpatient, or emergency room care, but who bill separately from the hospital itself. The information collected includes dates of visit, services provided, expenditures, and sources of payment. The form is in Attachment 58.

5) **Hospital Event Form –** The MPC collects information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but the medical records and administrative departments as well. Medical records departments are

contacted to determine the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by the medical records are billed separately from the hospital itself. HMO hospitals are included as part of this data collection effort. The form is in Attachment 59.

6) **Institutions (non-hospital) Event Form –** The MPC collects information on services and expenditures for household respondents who were admitted to a nursing home, rehabilitation center, or other non-hospital long-term health care facility. The form is in Attachment 60.

7) **Pharmacies Event Form –** The MPC collects information from both corporate and non-corporate pharmacies, including drug stores, grocery stores, discount stores, mail order, online, clinics, HMOs, and Hospitals. The information collected includes a patient profile of the household respondent that reflects a listing of prescriptions given to the respondent, and includes dates prescriptions filled, medicine name, other drug characteristics, and sources and amounts of payments made. The form is in Attachment 61.

Proposed Revisions for the Fall 2026 MEPS-HC:

- **MEPS Core Interview**- There are no major changes to the core interview. Minor changes to twenty-four questions are reflected in the attachments; the changes improve readability and respondents' understanding of the questions and response options.
- **Preventive Care Self-Administered Questionnaire (PSAQ):** The PSAQ will have the following changes for 2026:
    - Removing four questions on counseling and treatment, one question about birth control, two questions about aspirin use, and two questions about gender.
    - Reverting to the question used in the 2022 PSAQ about respondent sex.
    - Replacing two exercise items with five new items on exercise and strength training.
    - Adding questions about use of sleep medication, trouble getting to sleep, screen time, use of wearable devices, self-assessed diet quality, fruit and vegetable consumption, meals eaten away from home, former smoking, and weight loss attempt.
- **Burdens and Economic Impacts of Medical Care Self-Administered Questionnaire (ESAQ) and Diabetes Care Supplement (DCS)**: The ESAQ and DCS will be removed from the 2026 MEPS-HC.

This study is being conducted by AHRQ through its contractors, Westat for the MEPS-HC and RTI for the MEPS-MPC, pursuant to AHRQ's statutory authority to conduct and support research on health care and on systems for the delivery of such care, 42 U.S.C. 299a(a)(1), and to conduct a survey on the cost, use, and quality of health care. 42 U.S.C. 299b-2.

2. Purpose and Use of Information

The MEPS is a multi-purpose survey. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, consumer assessment of health care, health insurance coverage, demographic characteristics, employment and access to health care indicators. Estimates can be provided for individuals, families and population subgroups of interest. Data obtained in this study are used to provide, among others, the following national estimates:

- annual estimates of health care use and expenditures for persons and families
- annual estimates of sources of payment for health care utilizations, including public programs such as Medicare and Medicaid, private insurance, and out of pocket payments
- annual estimates of health care use, expenditures, and sources of payment of persons and families by type of utilization including inpatient stay, ambulatory care, home health, dental care and prescribed medications
- the number and characteristics of the population eligible for public programs including the use of services and expenditures of the population(s) eligible for benefits under Medicare and Medicaid
- the number, characteristics, and use of services and expenditures of persons and families with various forms of insurance
- annual estimates of consumer satisfaction with health care, and indicators of health care quality for key conditions
- annual estimates to track disparities in health care use and access

In addition to national estimates, data collected in this ongoing longitudinal study are used to study the determinants of the use of services and expenditures, and changes in the access to and the provision of health care in relation to:

- socio-economic and demographic factors such as employment or income
- the health status and satisfaction with health care of individuals and families
- the health needs and circumstances of specific subpopulation groups such as the elderly and children

To meet the need for national data on healthcare use, access, cost and quality, MEPS-HC collects information on:

- access to care and barriers to receiving needed care
- satisfaction with usual providers
- health status and limitations in activities
- medical conditions for which health care was used
- use, expense and payment (as well as insurance status of person receiving care) for health services

Given the twin problems of nonresponse and response error of some household reported data, information is collected directly from medical providers in the MEPS-MPC to improve the accuracy of expenditure estimates derived from the MEPS-HC. Because of

their greater level of precision and detail, MEPS also uses MEPS-MPC data as the main source of imputations of missing expenditure data. Thus, the MEPS-MPC is designed to satisfy the following analytical objectives:

- Serve as source data for household reported events with missing expenditure information
- Serve as an imputation source to reduce the level of bias in survey estimates of medical expenditures due to item nonresponse and less complete and less accurate household data
- Serve as the primary data source for expenditure estimates of medical care provided by separately billing doctors in hospitals, emergency rooms, and outpatient departments, Medicaid recipients and expenditure estimates for pharmacies
- Allow for an examination of the level of agreement in reported expenditures from household respondents and medical providers

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses, and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

3. Use of Improved Information Technology

MEPS-HC:
The MEPS-HC uses a combination of computer assisted personal interviewing (CAPI), computer assisted video interviewing (CAVI), and self-administered paper and web questionnaires. Use of CAVI for the MEPS-HC began in 2022 and offers the best of both telephone and in-person interviewing, while offering opportunities for cost savings and more accurate reporting. In 2022, the MEPS-HC began collecting signatures for authorization forms using one of three modes. Respondents can sign the form electronically, at the time of the in-person interview; sign electronically via Docusign when the eligible respondent was not available in person and an email or textable cell phone number was available; or sign on traditional hard copy paper authorization forms. Beginning in 2023, the MEPS-HC allowed two modes for completion of self-administered questionnaires, web and paper. A web survey is requested if an email or textable cell is available for the adult; otherwise, a paper survey is offered for completion. More recently, a machine learning pipeline reviews recordings from computer-assisted recorded interviewing (CARI) to both validate that there are two speakers and evaluate for proper question administration. Results from the pipeline help prioritize cases for human review.

MEPS-MPC:
The mode of administration for the MEPS-MPC (including the pharmacy component) varies based on the preferences of the provider and includes phone interviews, mail, fax, and electronic submission of information. Starting with the 2009 MEPS-MPC data collection, a computer-assisted system was developed for both interviewing and record abstraction. This Integrated Data Collection System (IDCS) supported the effort to recruit providers by telephone and to interview medical records and billing staffs of medical facilities. For providers that prefer to send hard copy records, the IDCS is used to abstract information from medical records and patient accounts. The IDCS consists of two main systems: 1) a Web component in ASP.Net in which the MEPS-MPC forms (Contact Guides and Event Forms) are programmed for either data entry either during telephone calls or record abstraction and 2) a Case Management System (CMS) that manages the medical providers and associated forms for call scheduling, contact information, appointment times, and event/status information.

Table 1. Percent of respondents expected to report their data electronically.

Data Collection	Percent
1. MEPS-HC Core Interview (CAVI)	35%
2. MEPS-HC SAQs (web)	85%
3. MEPS-HC Authorization Forms (eSig or Docusign)	99%
4. MEPS-MPC	5.2%

4. Efforts to Identify Duplication

There is no other survey that is now or has been recently conducted that will meet all of the objectives of the MEPS. Some federal surveys do collect health insurance information

from households (SIPP, NHIS); however, these surveys do not collect the depth of information on health care use and expenses available in the MEPS. Moreover, MEPS is the only survey which links information collected from households with information collected from medical providers to inform the estimation of expenditures.

5. Involvement of Small Entities

The MEPS-HC collects information only from households. The MEPS-MPC will survey medical facilities, physicians, and pharmacies. Some of the MPC respondents may be small businesses. The MEPS-MPC instrument and procedures used to collect data are designed to minimize the burden on all respondents.

6. Consequences if Information Collected Less Frequently

The design of the MEPS-HC in which households are contacted 5 times over the course of 2 years enables the gathering of medical use data at the event level and permits the estimation of expenditures and payments for persons by event type. Reducing the number of rounds in which the data are collected would hamper the availability and quality of information due to long recall periods.

MEPS-MPC respondents are contacted at least once during the calendar year for the preceding data collection year. Sometimes a follow up contact is necessary to clarify ambiguous or collect missing information. Contacts on a less frequent basis than the envisioned timetable jeopardizes the access of the study to information from records that could otherwise be destroyed or archived.

7. Special Circumstances

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

8. Federal Register Notice and Outside Consultations

8.a. Federal Register Notice

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on December 30, 2025 (*90, 61150)* for 60 days (see Attachment 62). AHRQ received three sets of comments in all. The Bureau of Economic Analysis sent a strong letter of support. The American Academy of Sleep Medicine supported inclusion of questions addressing sleep medication use and difficulty sleeping and provided suggestions for additional questions. AHRQ will evaluate the suitability of these questions for future inclusion in the MEPS.

Finally, the IPUMS Center for Data Integration at the University of Minnesota expressed support of the continuation of MEPS data collection and concerns about the elimination of the questions on sexual orientation and gender identity and birth control; removal of the Burdens and Economic Impacts of Medical Care Self-Administered Questionnaire (ESAQ); and removal of the Diabetes Care Supplement (DCS). The sexual orientation and gender identity questions were previously removed from MEPS pursuant to Executive Order 14168. AHRQ continues to propose dropping the single question on

counseling on birth control given the limited space available on the PSAQ in favor of questions reflecting current MAHA priorities. The ESAQ was a one-time supplement funded by the Office of the Secretary Patient-Centered Outcomes Research Trust Fund. ESAQ data will be released in August 2026 on the public use 2024 MEPS Full Year Consolidated File as previously planned. AHRQ continues to propose removal of the current Diabetes Care Supplement. The DCS in its current form is costly to field and process, outdated (having been last revised in 2008), and contains several questions where respondent recall is questionable. AHRQ will consider a shortened, updated version of the DCS as well as topical modules on care for other chronic conditions for future inclusion in the MEPS on a periodic basis. The MEPS continues to collect detailed information about health care utilization and spending related to diabetes care management, including specific medications.

8.b. Outside Consultations

Individuals or groups outside the Agency consulted about the MEPS project over the last several years are listed below:

Table 1. MEPS Consultants

Name	Affiliation
Joel Cohen, PhD	Independent Consultant
Carlos Blanco, PhD	National Institute of Drug Abuse
Stephen Blumberg, PhD	Centers for Disease Control and Prevention National Center for Health Statistics
Kosali Simon, PhD	Indiana University
Thomas Buchmueller, PhD	University of Michigan, Ross School of Business
Katherine G. Abraham, PhD	Committee on National Statistics and University of Maryland
Jonaki Bose, M. Sc	Centers for Disease Control and Prevention National Center for Health Statistics
Abe C. Dunn, PhD	Bureau of Economic Analysis, U.S. Department of Commerce
Todd Wagner, PhD	Health Economics Research Center, Department of Veterans Affairs and Stanford University
Lynn Blewett, PhD	University of Minnesota, IPUMS Health Surveys

AHRQ consults with persons outside the agency, including within HHS, to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported. These consultations include:

- Ongoing consultations with other agencies in the department through the HHS Data Council
- Regular discussions with staff from NCHS on sample design and disclosure issues. All MEPS data elements appearing on the MEPS Public Use Files are reviewed and cleared by the NCHS Data Review Board

- Regular consultations with staff from the IPUMS-MEPS Health Surveys team at the University of Minnesota on data availability, data elements, reporting formats, and other issues. The IPUMS-MEPS project is a major disseminator of MEPS data (with support from the NIH)

- Regular participation in monthly meetings of the MEPS Working Group organized by the National Cancer Institute, which has sponsored several supplemental MEPS self-administered questionnaires most recently in 2024.

- Panel Session "Modernization of the Medical Expenditure Panel Survey (MEPS)" at the 2024 Academy Health Annual Research Meeting where AHRQ solicited ideas through formal presentations by long-time MEPS users Kosali Simon, Indiana University, and Thomas Buchmueller, U. of Michigan Ross School of Business and from audience members.

There are no unresolved issues from these consultations.

9. Payments/Gifts to Respondents

MEPS-HC respondents will be offered a monetary gift as a token of appreciation for their participation in the MEPS. A gift has been offered to respondents at the end of each round since the inception of MEPS in 1996; the current amount of $50 per round has been in place since 2011 (OMB approval obtained January 26, 2010, version 1). For household respondents, participation includes not only time being interviewed but also keeping track of their medical events and expenditures between interviews. Household respondents will be informed of the gift at the first in-person contact and all eligible respondents will be given the same amount.

10. Assurance of Confidentiality

Data will be kept private to the extent allowed by law. Individuals and organizations will be assured of the confidentiality of their replies under Section 944(c) of the Public Health Service Act. 42 U.S.C. 299c-3(c). That law requires that information collected for research conducted or supported by AHRQ that identifies individuals or establishments be used only for the purpose for which it was supplied. This research project will be carried out in compliance with these confidentiality statutes.

Information that can directly identify the respondent, such as name and contact information will be collected. MEPS contractors develop and operate all information systems in conformance with the standards set forth by the Federal Information Security Management Act (FISMA) and National Institute of Standards and Technology (NIST) Special Publication (SP) 800-37, Guide for the Security Certification and Accreditation of Federal Information Systems. Field interviewer laptops remove interview data after transmission of a completed survey. Hard copy materials are kept locked in secure areas and are destroyed as soon as they are no longer needed.

All contractor staff sign an affidavit that outlines the importance of confidentiality, individual responsibilities, and the applicable laws and penalties for unauthorized

disclosure. Data collection staff are subject to background checks, receive extensive training about confidentiality and data security, and are monitored by supervisors. Project staff complete annual data security training. The Data Security Plan (see Appendix A) provides additional information about the security procedures implemented for MEPS, including the safe transmission of data and its confidentiality requirements.

In accordance with 5 CFR § 1320.8(b)(3) the following Privacy Act statement is printed on the MEPS data collection forms. This survey is authorized under 42 U.S.C. 299a. Privacy is protected by the Privacy Act and Section 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. The confidentiality of your responses to this survey is protected by Section 944(c) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. The estimated time to complete each form in the survey is shown in Exhibit 1 for each form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. This information collection is voluntary. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (OMB control number 0935-0118) Email: REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

11. Questions of a Sensitive Nature

The MEPS questionnaires for the Household Component include questions on income and medical conditions that some respondents may perceive as sensitive. These questions are necessary for MEPS to meet the goals described in section 1.

12. Estimates of Annualized Burden Hours and Costs

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS-HC and the MEPS-MPC.

MEPS-HC:

1. *MEPS-HC Core Interview* - completed by 10,350 "family level" respondents. Since the MEPS-HC typically consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS-HC core requires an average response time of 87 minutes to administer.
2. *Adult SAQ* - completed once during the 2-year panel, in rounds 2 and 4 during odd numbered years, making the annualized average 0.5 times per year. The Adult SAQ will be completed by 12,395 adults and requires an average of 7 minutes to complete.
3. *PSAQ* - completed once during the 2-year panel, in rounds 2 and 4 during even numbered years, making the annualized average 0.5 times per year. The PSAQ will be completed by 12,395 adults and requires an average of 7 minutes to complete.

4. *Authorization forms for the MEPS-MPC and Pharmacy Survey* - completed by 17,388 individual respondents. Each respondent will complete an average of 3.6 forms each year, with each form requiring an average of 3 minutes to complete.
5. *Validation interview* - conducted with approximately 1,491 respondents each year and requires 5 minutes to complete.

The total annual burden hours for the respondent's time to participate in the MEPS-HC is estimated to be 42,219 hours.

MEPS-MPC:

1. *Contact Guide/Screening Call* - conducted with 36,370 providers and pharmacies each year and requires 5 minutes to complete.
2. *Home Health Care Providers Event Form* - completed by 505 providers, with each provider completing an average of 5.66 forms and each form requiring 3 minutes to complete.
3. *Office-based Providers Event Form* - completed by 8,074 providers. Each provider will complete an average of 3.58 forms, and each form requires 3 minutes to complete.
4. *Separately Billing Doctors Event Form* - will be completed by 5,574 providers, with each provider completing 1.13 forms on average, and each form requiring 3 minutes to complete.
5. *Hospital Event Form* - completed by 3,482 hospitals or HMOs. Each hospital or HMO will complete 5.64 forms on average, with each form requiring 3 minutes to complete.
6. *Institutions (non-hospital) Event Form* - completed by 103 institutions, with each institution completing 1.25 forms on average, and each form requiring 3 minutes to complete.
7. *Pharmacy Event Form* - completed by 2,008 pharmacies. Each pharmacy will complete 21.15 forms on average, with each form requiring 3 minutes to complete.

The total burden hours for the respondent's time to participate in the MEPS-MPC is estimated to be 8,045 hours. The total annual burden hours for the MEPS-HC and MPC are estimated to be 50,264 hours.

Exhibit 1. MEPS-HC and MPC estimated annualized respondents and burden hours, 2026 to 2028

Form Name	Number of Respondents[a]	Number of responses per respondent	Hours per response	Total Burden hours
MEPS-HC				
1. MEPS-HC Core Interview	10,350	2.5	87/60	37,519
2. Adult SAQ[*]	12,395	0.5	7/60	723
3. Preventive Care SAQ (PSAQ)[**]	12,395	0.5	7/60	723
4. Authorization forms for the MEPS-MPC Provider and Pharmacy Survey	17,388	3.6	3/60	3,130
5. MEPS Validation Interview	1,491	1	5/60	124
Subtotal for the MEPS-HC	54,019	--	--	42,219
MEPS-MPC				
1. Contact Guide/Screening Call	36,370	1	5/60	3,031
2. Home Health Care Providers Event Form	505	5.66	3/60	143
3. Office-based Providers Event Form	8,074	3.58	3/60	1,445
4. Separately Billing Doctors Event Form	5,574	1.13	3/60	315
5. Hospitals & HMOs (Hospital Event Form)	3,482	5.64	3/60	982
6. Institutions (non-hospital) Event Form	103	1.25	3/60	6
7. Pharmacies Event Form	2,008	21.15	3/60	2,123
Subtotal for the MEPS-MPC	56,116	--	--	8,045
GRAND TOTAL	110,135			50,264

[*] The Adult SAQ is completed once every two years, on the odd numbered years.

[**] The PSAQ is completed once every two years, on the even numbered years.

[a] See the Supporting Statement Part B, Table 1 and Table 3, for information on the sample size and number of respondents.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS-HC is estimated to be $2,757,745 and the annual cost burden for the MEPS-MPC is estimated to be $350,960. The total annual cost burden for the MEPS-HC and MPC is estimated to be $3,108,705.

Exhibit 2. Estimated annualized cost burden

Form Name	Total burden hours	Average hourly wage rate*	Adjusted Hourly Wage Rate**	Total cost burden
MEPS-HC				
1. MEPS-HC Core Interview	37,519	$32.66[a]	$65.32	$2,450,741
2. Adult SAQ[*]	723	$32.66[a]	$65.32	$47,226
3. Preventive Care SAQ (PSAQ)[**]	723	$32.66[a]	$65.32	$47,226
4. Authorization forms for the MEPS-MPC Provider and Pharmacy Survey	3,130	$32.66[a]	$65.32	$204,452
5. MEPS Validation Interview	124	$32.66[a]	$65.32	$8,100
Subtotal for the MEPS-HC	42,219	--		$2,757,745
MEPS-MPC				
1. Contact Guide/Screening Call	3,031	$21.91[b]	$43.82	$132,818
2. Home Health Care Providers Event Form	143	$21.91[b]	$43.82	$6,266
3. Office-based Providers Event Form	1,445	$21.91[b]	$43.82	$63,320
4. Separately Billing Doctors Event Form	315	$21.91[b]	$43.82	$13,803
5. Hospitals & HMOs (Hospital Event Form)	982	$21.91[b]	$43.82	$43,031
6. Institutions (non-hospital) Event Form	6	$21.91[b]	$43.82	$263
7. Pharmacies Event Form	2,123	$21.54[c]	$43.08	$91,459
Subtotal for the MEPS-MPC	8,045	--		$350,960
Grand Total	50,264	--		$3,108,705

* National Compensation Survey: Occupational wages in the United States May 2024, "U.S. Department of Labor, Bureau of Labor Statistics."

** The Adjusted Hourly Rate was estimated at 200% of the hourly wage.

[a] Mean hourly wage for All Occupations (00-0000)

[b] Mean hourly wage for Medical Secretaries (43-6013)

[c] Mean hourly wage for Pharmacy Technicians (29-2052)

13. Estimates of Annualized Respondent Capital and Maintenance Costs

Capital and maintenance costs include the purchase of equipment, computers or computer software or services, or storage facilities for records, as a result of complying with this data collection. There are no direct costs to respondents other than their time to participate in the study.

14. Estimates of Total and Annualized Cost to the Government

Exhibit 3 shows the remuneration paid to providers is estimated to be $313,848. Exhibit 4 shows the total and annualized costs associated with the design and data collection of the MEPS-HC and MEPS-MPC is estimated to be $61,197,703 in each of the three years covered by this ICR. Exhibit 5 shows the annualized cost of MEPS-HC and MEPS-MPC oversight to be $2,385,688. The sum of the totals in the three exhibits is the total annualized cost to the government of $63,897,239.

Exhibit 3. Total and Average Annual Remuneration by Provider Type for the MEPS-MPC

Provider Type	Number of Records with Payment	Average Payment	Total Remuneration
Hospital	737	$42.42	$31,264
Office Based Providers	395	$29.12	$11,502
Institutions	3	$95.67	$287
Home Care Provider (Health Care Providers)	1	$2	$2
Home Care Provider (Non-Health Care Providers)	0	$0	$0
Pharmacy	8,345	$31.66	$264,203
Separately Billing Doctors	137	$48.10	$6,590
Total MPC	9,618	---	$313,848

Exhibit 4. Estimated Total and Annualized Cost for Design and Data Collection

Cost Component	Total Cost	Annualized Cost
Sampling Activities	$3,819,729	$1,273,243
Instrumentation and Sample Management System	$13,286,430	$4,428,810
Interviewer Recruitment and Training	$12,679,518	$4,226,506
Data Collection Activities	$95,614,227	$31,871,409
Data Processing	$25,619,760	$8,539,920
Production of Public Use Data Files	$23,495,043	$7,831,681
Project Management	$9,078,402	$3,026,134
Total	$183,593,109	$61,197,703

Exhibit 5. Annualized Cost to AHRQ for MEPS-HC and MPC oversight

AHRQ Position	Estimated Hours	Hourly Rate	Adjusted Hourly Rate	Annualized Cost
GS15/5	3,384	$91.32	$182.64	$ 618,054
GS14/5	5,020	$77.64	$155.28	$779,506
GS13/5	7,520	$65.70	$131.40	$988,128
Total	15,924			$2,385,688

Annual salaries based on 2025 OPM Pay Schedule for Washington/DC area: http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2025/DCB.pdf

** The Adjusted Hourly Rate was estimated at 200% of the hourly wage

15. Changes to Collection of Information Requirements, Burden, and Collection of Information Instruments

The burden estimate for the MEPS-HC and MPC is reduced by 17,225 hours from 67,489 hours previously approved to 50,264 hours in this ICR. This reduction comes from removal of the ESAQ (1,348 hours) and the DCS (70 hours); reductions in the MEPS-HC responding sample size due to continued post-pandemic response rate challenges contributing to fewer responses to the core interview and SAQs (8,178 hours); and subsequent reductions in the MEPS-MPC sample, which comes from the MEPS-HC plus lower pharmacies event form response rates (7,629 hours).

16. Time Schedule, Publication and Analysis Plans

Data collected from the MEPS will be used in a variety of descriptive analysis. AHRQs' website https://meps.ahrq.gov/mepsweb/ contains examples of publications. Those publications include statistical briefs, research findings, chartbooks, and journal articles. In addition, tabular data is presented on the website. Special analytic reports will be issued on an ad-hoc basis, and other analyses will be presented at annual meetings of professional associations and in professional journals.

To the extent possible, given our commitment to respondent confidentiality, AHRQ endeavors to release public use files from this project as soon as possible. Collection for each data year ends in June of the following year, when MPC collection also occurs. Public use files are then released by August of the next year after completion of data processing, editing, variable construction, imputation, documentation, and disclosure review.

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

Appendix A – Data Security Plan
Attachment 1 – Access to Care
Attachment 2 – Additional Healthcare Questions
Attachment 3 – Assets
Attachment 4 – Calendar Section
Attachment 5 – Closing Section
Attachment 6 – Contacting Module Section
Attachment 7 – Charge Payment Section
Attachment 8 – Child Preventive Health Section
Attachment 9 – Dental Visit Section
Attachment 10 – Event Driver Section
Attachment 11 – Event Enumeration Section
Attachment 12 -- Event Follow-Up Section
Attachment 13 -- Employment Section
Attachment 14 -- Employment Driver Section
Attachment 15 -- Emergency Room Section
Attachment 16 -- Event Roster Section
Attachment 17 -- Employment Wages Section

Attachment 18 -- Flat Fee Section
Attachment 19 -- Food Security Section
Attachment 20 -- Financial Well-Being Section
Attachment 21 -- Global Section
Attachment 22 -- Health Status Section
Attachment 23 -- Home Health Section
Attachment 24 -- Health Insurance Detail Section
Attachment 25 -- Time Period Covered Detail Section
Attachment 26 -- Hospital Stay Section
Attachment 27 -- Health Insurance Section
Attachment 28 -- Institutional Care Stay Section
Attachment 29 -- Income Section
Attachment 30 – Managed Care Section
Attachment 31 -- Medical Visit Section
Attachment 32 -- Old Empl-Priv Related Ins Section
Attachment 33 -- Off Path Navigation Section
Attachment 34 -- Other Medical Expenses Section
Attachment 35 -- Outpatient Department Section
Attachment 36 -- Priority Condition Enumeration Section
Attachment 37 -- Prescribed Medicines Section
Attachment 38 -- Provider Probes Section
Attachment 39 -- Old Public Related Insurance Section
Attachment 40 -- Provider Roster Section
Attachment 41 -- Quality Supplement Section
Attachment 42 -- Reenumeration A Section
Attachment 43 -- Reenumeration B Section
Attachment 44 -- Respondent Forms Section
Attachment 45 -- Review of Employment Section
Attachment 46 -- Start-Restart Section
Attachment 47 -- Telehealth Section
Attachment 48 -- MEPS-HC Show Cards
Attachment 49 -- Adult SAQ
Attachment 50 – PSAQ
Attachment 51 -- Permission Form for Medical Providers
Attachment 52 -- Permission Form for Pharmacies
Attachment 53a -- Validation Letter
Attachment 53b -- Phone Validation Form
Attachment 54 -- MPC Contact Guide & Screening Call
Attachment 55 -- Home Healthcare for Healthcare Providers
Attachment 56 -- Home Healthcare for Non-healthcare Providers
Attachment 57 -- Office Based Provider Event Form
Attachment 58 -- Separately Billing Doctors Event Form
Attachment 59 -- Hospital Event Form
Attachment 60 -- Institutions (non-hospital) Event Form
Attachment 61 -- Pharmacies Event Form
Attachment 62 – Federal Register Notice