CENTER FOR REGULATORY FREEDOM
PROJECT OF CPAC FOUNDATION

515 KING STREET, ALEXANDRIA VA 22314

M E M O R A N D U M

To: **Hon. Robert F. Kennedy, Jr., Secretary, US Department of Health and Human Services**
Dr. Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services
From: **Andrew Langer, Director, Center for Regulatory Freedom**
Date: **April 14, 2026**
Re: **Comments to US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) in response to an Information Collection Request, "CMS-10488 (QHP Enrollee Survey, CMS-R-284 (T-MSIS), CMS-10407 (SBC)," Docket #CMS-2026-0596, Fed. Reg. 2026-02871, Published February 13, 2026**

Below are comments of the American Conservative Union Foundation's (d/b/a. Conservative Political Action Coalition Foundation) (hereinafter "CPAC Foundation") Center for Regulatory Freedom (hereinafter "CRF"), in response to an Information Collection Request, "CMS-10488 (QHP Enrollee Survey, CMS-R-284 (T-MSIS), CMS-10407 (SBC)," Docket #CMS-2026-0596, Fed. Reg. 2026-02871, published February 13, 2026.

CRF is a project of the CPAC Foundation, a non-profit, non-partisan 501(c)(3) research and education foundation. Our mission is to inject a common-sense perspective into the regulatory process, to ensure that the risks and costs of regulations are fully based on sound scientific and economic evidence, and to ensure that the voices, interests, and freedoms of Americans, and especially of small businesses, are fully represented in the regulatory process and debates. Finally, we work to ensure that regulatory proposals address real problems, that the proposals serve to ameliorate those problems, and, perhaps most importantly, that those proposals do not, in fact, make public policy problems worse.

INTRODUCTION

The CPAC Foundation Center for Regulatory Freedom (CRF) submits these comments in response to the request by the Centers for Medicare & Medicaid Services (CMS) for public input on the proposed information collections under the Paperwork Reduction Act (PRA). CRF appreciates the opportunity to provide feedback on these collections at this stage of review, particularly given the central role that information collection plays in the administration of federal health programs. The PRA establishes an important framework intended to ensure that

federal agencies collect only that information which is necessary, useful, and appropriately calibrated to minimize burden. In practice, however, the effectiveness of that framework depends on rigorous engagement—both by agencies and stakeholders—with the design, scope, and implementation of specific collections. These comments are therefore offered with the objective of promoting disciplined, analytically grounded information collection practices that enhance program performance while avoiding unnecessary or counterproductive administrative burdens.

Information collections are often characterized as purely administrative or operational tools, designed to facilitate program management and oversight. While this characterization is partially accurate, it is increasingly incomplete. In modern regulatory and programmatic contexts, information collections function not only as mechanisms for data gathering, but also as instruments that shape behavior across regulated entities, influence incentives, and structure interactions between government and the marketplace. As such, they occupy a dual role: they are both operational inputs and policy levers. This dual role has become more pronounced as agencies rely more heavily on data-driven frameworks to inform decision-making, evaluate performance, and communicate information to consumers. In the context of CMS programs in particular, information collections are now embedded in core program functions, including plan comparison, quality measurement, payment adjustment, and long-term policy development.

The collections at issue in this notice illustrate the extent to which information collection activities can shape real-world outcomes. Data gathered through these instruments influences how consumers evaluate coverage options, how providers and plans allocate resources, and how regulators assess compliance and performance. In this sense, information collections do not merely reflect underlying market conditions—they actively participate in shaping them. They can alter incentives, affect competitive dynamics, and contribute to the formation of regulatory expectations, even in the absence of formal rulemaking. For these reasons, it is essential that such collections be designed and implemented with a level of analytical rigor comparable to that applied in traditional regulatory processes. Absent such rigor, there is a risk that information collection frameworks will produce unintended distortions, impose disproportionate burdens, or generate data that is of limited practical utility.

The PRA provides a clear statutory framework intended to guide agencies in the development and implementation of information collections. At its core, the PRA requires agencies to demonstrate that proposed collections are necessary for the proper performance of agency functions, that they have practical utility, and that they minimize burden on respondents to the greatest extent practicable. These requirements are not merely procedural—they are substantive constraints designed to ensure that information collection remains disciplined, targeted, and efficient. However, in practice, there is often a tendency to treat these requirements as formalities rather than as binding analytical standards. As a result, burden estimates may fail to capture the full scope of compliance costs, including system modifications, staff training, and operational adjustments, while assertions of utility may be framed in broad or generalized terms that do not clearly distinguish between primary and secondary uses of the data.

CRF's comments focus on three information collections included in this notice: the Qualified Health Plan (QHP) Enrollee Experience Survey (CMS–10488), the Transformed Medicaid Statistical Information System (T-MSIS) data collection (CMS–R–284), and the Summary of

Benefits and Coverage (SBC) and Uniform Glossary requirements (CMS–10407). These collections were selected for detailed analysis based on their scale, their integration into core program functions, and their potential to influence market behavior and policy outcomes. Other collections included in the notice are more limited in scope and do not raise the same systemic considerations. By focusing on these three collections, CRF seeks to engage where the potential impact—both positive and negative—is most significant, and where disciplined design and implementation can yield meaningful improvements in program performance and administrative efficiency.

Across these collections, several recurring concerns emerge. First, there is evidence of methodological drift over time, as collections are modified incrementally without sufficient attention to the implications for longitudinal consistency and comparability. Second, burden estimates frequently appear to understate the full range of costs imposed on respondents, particularly with respect to information technology systems, data integration, and ongoing compliance processes. Third, there is a pattern of data-use expansion, in which information initially collected for one purpose is subsequently used for additional functions—such as regulatory oversight or public reporting—without a corresponding reassessment of necessity and utility. Finally, there is a lack of clearly articulated limiting principles governing the scope and evolution of information collections, raising concerns about cumulative burden and the potential for mission creep.

CRF supports CMS's broader objectives of promoting transparency, improving consumer access to information, and enhancing the performance of federal health programs. Information collection plays an essential role in achieving these objectives, and well-designed data systems can contribute significantly to more efficient and effective program administration. At the same time, these benefits are not automatic. They depend on the extent to which information collections are carefully calibrated to align with clearly defined purposes, supported by sound methodology, and implemented in a manner that minimizes unnecessary burden. Accordingly, the recommendations set forth in these comments are intended not to constrain CMS's ability to collect and use data, but to ensure that such activities are carried out in a disciplined, analytically rigorous manner that advances statutory objectives while preserving flexibility, efficiency, and accountability.

EXECUTIVE SUMMARY

Information collections administered by the Centers for Medicare & Medicaid Services (CMS) increasingly function not merely as administrative tools, but as mechanisms that shape market behavior, influence consumer decision-making, and inform regulatory oversight. In this respect, they operate as a form of quasi-regulation, exerting material effects on regulated entities and program outcomes without undergoing the same level of scrutiny typically applied to formal rulemaking. This dynamic heightens the importance of ensuring that such collections are designed and implemented with clearly bounded scope and strong methodological integrity. Absent these guardrails, information collections risk imposing unnecessary burden, generating data of limited utility, and introducing distortions into program administration and market dynamics. CRF's comments therefore focus on reinforcing the need for disciplined analytical

frameworks, transparent design choices, and a consistent alignment between the stated purposes of data collection and their real-world application.

Our arguments are laid out as follows:

CMS–10488 (QHP Enrollee Experience Survey)

- **The survey functions as a de facto regulatory lever, shaping plan behavior and influencing consumer choice beyond its stated purpose as a measurement tool**
- **Proposed revisions risk breaking longitudinal comparability and introducing measurement bias, undermining the reliability of trend analysis and benchmarking**
- **Expanded oversampling authority lacks sufficient guardrails, creating the potential for distorted comparisons and unintended bias**
- **Assertions of burden reduction are not supported by the proposed changes, which introduce additional outreach and screening mechanisms**

CMS–R–284 (T-MSIS)

- **The expansion of data fields proceeds without clearly defined use cases, raising concerns about necessity and scope discipline**
- **The addition of immigration-related identifiers requires a more explicit justification tied to programmatic need and statutory authority**
- **The claim of "no burden change" likely understates the operational and compliance costs imposed on states, particularly with respect to system updates and data integration**
- **There is a need for stronger data minimization principles and governance discipline to ensure that the collection remains targeted and efficient**

CMS–10407 (Summary of Benefits and Coverage)

- **Standardization of disclosure formats does not, in itself, guarantee usability or meaningful consumer comprehension**
- **There is a risk of achieving formal compliance without delivering substantive consumer benefit, particularly if materials are not effectively used in real-world decision-making**
- **The ongoing administrative burden associated with these requirements should be periodically reassessed relative to demonstrated utility**

Taken together, these issues underscore the need to pair ongoing modernization efforts with a disciplined approach to information collection. As CMS continues to refine and expand its data systems, it is essential that such efforts be grounded in analytical rigor, guided by clearly defined use-case limitations, and calibrated to ensure that the burden imposed on regulated entities is proportionate to the utility of the information collected.

I. CROSS-CUTTING PRA CONCERNS

The information collections addressed in this notice raise a set of common issues that extend beyond any single instrument and instead reflect broader patterns in the design and evolution of CMS data collection practices. While each collection serves a distinct programmatic purpose, they share structural characteristics that warrant cross-cutting analysis under the Paperwork Reduction Act (PRA). Evaluating these collections in isolation risks overlooking systemic concerns that, taken together, shape the overall burden imposed on regulated entities and the quality and utility of the data produced. Accordingly, this section identifies and examines those recurring issues, with the goal of providing a coherent analytical framework that can be applied across CMS information collection activities. Such a framework is necessary to ensure that incremental changes to individual collections do not cumulatively result in disproportionate burden or diminished effectiveness.

A central consideration in this analysis is the recognition that information collection is not a neutral administrative exercise. Data collection requirements influence the behavior of regulated entities, shape incentives, and affect how organizations allocate resources and structure their operations. When entities are required to report specific data elements, they often adjust internal processes to ensure compliance, sometimes prioritizing measurable activities over those that may be equally or more important but less readily captured. In this way, information collections can operate as implicit policy tools, steering behavior without the formal processes associated with rulemaking. This dynamic underscores the need for careful design and clear justification, as even seemingly minor changes to data requirements can have meaningful downstream effects on program participation and market behavior.

One of the most persistent challenges in the PRA context is the tendency to underestimate the true burden associated with information collection. Official burden estimates often focus on the time required to complete forms or submit data, but they frequently exclude the broader set of activities necessary to comply with reporting requirements. These include modifications to information technology systems, integration of new data fields into existing workflows, development of compliance infrastructure, and training of personnel. In many cases, these indirect costs exceed the direct time burden associated with data submission. Failure to account for these factors can result in a significant understatement of the real-world impact of information collection requirements, undermining the PRA's objective of minimizing burden to the greatest extent practicable.

Relatedly, the resources devoted to compliance with information collection requirements carry meaningful opportunity costs. Time, capital, and personnel allocated to data reporting are resources that cannot be used for other purposes, including patient care, service delivery, or innovation. Particularly in resource-constrained environments, these tradeoffs are not theoretical—they directly affect organizational priorities and outcomes. When information collection requirements are not carefully calibrated to deliver commensurate utility, they risk diverting resources away from activities that provide more direct value to beneficiaries and the healthcare system as a whole. A disciplined approach to information collection must therefore incorporate an explicit consideration of these opportunity costs, ensuring that the benefits of data collection justify the resources expended.

Another recurring issue is the ambiguity surrounding the utility of collected data. CMS often describes information collections in terms of multiple potential uses, including program administration, consumer information, regulatory oversight, and research. While each of these uses may be valid, they are not always clearly distinguished, and the relative importance of each is seldom articulated. This aggregation of purposes can obscure whether specific data elements are necessary for the primary function of the collection or are being retained to support secondary or speculative uses. Without clear differentiation between primary and secondary uses, it becomes difficult to assess whether the scope of the collection is appropriately limited or whether certain data elements could be modified or eliminated without impairing core program functions.

Over time, information collections tend to expand in both scope and function, a phenomenon commonly referred to as scope creep. Additional data fields are added, new reporting requirements are layered onto existing frameworks, and previously collected data are repurposed for new uses. While such evolution may be driven by legitimate programmatic needs, it often occurs incrementally and without a comprehensive reassessment of the overall collection. As a result, collections can become more complex and burdensome over time, even if each individual change appears modest in isolation. The absence of periodic, holistic review increases the risk that information collections will drift away from their original purpose and impose cumulative burdens that are disproportionate to their utility.

Frequent revisions to information collections also raise concerns regarding longitudinal integrity. Many CMS data systems are used to track trends over time, evaluate program performance, and inform policy decisions. Changes to survey instruments, data definitions, or reporting methodologies can disrupt these analyses by introducing discontinuities or altering the meaning of key variables. When such changes are not carefully managed and documented, they can reduce the comparability of data across time periods and undermine the reliability of conclusions drawn from the data. Maintaining longitudinal consistency, or at a minimum clearly accounting for changes that affect comparability, is essential to preserving the analytical value of CMS data collections.

A related concern is the absence of clearly articulated limiting principles governing the scope and duration of information collections. The PRA establishes general requirements regarding necessity and burden minimization, but it does not, in practice, impose a structured framework for determining when data collection should be reduced, modified, or discontinued. As a result, once data elements are incorporated into a collection, they are rarely removed, even if their utility diminishes over time. This dynamic contributes to the accumulation of requirements and reinforces the need for a more explicit approach to data governance—one that includes criteria for both the addition and the removal of data elements based on demonstrated need and performance.

In light of these cross-cutting concerns, CRF recommends that CMS adopt a more disciplined and transparent approach to information collection design and management. This approach should include the implementation of burden-to-utility calibration, ensuring that each data element is justified by a clearly defined and demonstrable use case. CMS should also establish explicit limitations on the scope of data collection, including mechanisms to prevent the

expansion of collections beyond their original purpose without formal reassessment. Finally, periodic reviews should be conducted to evaluate the continued necessity and effectiveness of existing collections, with a willingness to streamline or eliminate requirements that no longer serve a meaningful function. By incorporating these principles, CMS can better align its information collection activities with the objectives of the PRA while enhancing the efficiency and effectiveness of its programs.

II. CMS–10488: QHP ENROLLEE EXPERIENCE SURVEY

Among the information collections addressed in this notice, the Qualified Health Plan (QHP) Enrollee Experience Survey (CMS–10488) is the most significant in terms of its scale, its integration into core program functions, and its influence on both market behavior and regulatory outcomes. Administered by the Centers for Medicare & Medicaid Services, the survey serves as a central component of the Exchanges' consumer information infrastructure and is increasingly embedded in broader performance evaluation frameworks. As such, changes to the design, administration, or interpretation of this survey carry implications that extend well beyond data collection itself, affecting how plans compete, how consumers make decisions, and how CMS evaluates program performance.

The stated purposes of the QHP Enrollee Experience Survey are multifaceted. It is intended to provide consumers with actionable information to compare health plans, to offer plans feedback that can be used to improve performance, and to supply regulators and accreditation bodies with data to support oversight and evaluation. Each of these functions is significant in its own right, and together they position the survey as a central node in the Exchange ecosystem. However, the combination of these roles also introduces complexity, as the survey must simultaneously serve as a consumer-facing tool, a quality improvement mechanism, and an input into regulatory processes. This multiplicity of purposes heightens the importance of ensuring that the survey's design is methodologically sound and appropriately bounded.

In practice, the QHP Enrollee Experience Survey functions not only as a measurement instrument but also as a market signal and an implicit regulatory mechanism. The metrics derived from the survey influence plan ratings, affect consumer choice, and can shape how plans allocate resources to improve perceived performance. Plans may adjust operational priorities in response to survey domains, emphasizing areas that are measured while potentially deprioritizing those that are not. In this way, the survey exerts a normative effect on plan behavior, effectively guiding market outcomes without the formal processes associated with rulemaking. This dynamic underscores the need for heightened analytical rigor, as changes to the survey can have cascading effects throughout the system.

CMS proposes several modifications to the survey instrument and its administration. These include the removal of questions related to tobacco use, revisions to demographic questions to align with updated federal standards, updates to telehealth-related items, and the addition of gate questions designed to screen respondents out of inapplicable follow-up items. CMS also proposes changes to sampling protocols, including expanded flexibility for oversampling, as well as modifications to outreach efforts, such as additional email reminders and extended telephone

follow-up periods. While each of these changes may be individually justified, their combined effect warrants careful evaluation, particularly with respect to their impact on data consistency and respondent burden.

One of the primary concerns associated with these proposed changes is the potential disruption of longitudinal comparability. The QHP Enrollee Experience Survey has historically been used to track trends over time, enabling comparisons across plan years and supporting benchmarking efforts. Modifications to survey questions, response options, or sampling methodologies can introduce discontinuities that complicate or undermine these analyses. Even relatively minor changes can alter how respondents interpret questions or how responses are categorized, leading to shifts in measured outcomes that reflect methodological changes rather than actual differences in performance. Preserving the integrity of longitudinal data is essential to maintaining the survey's value as a tool for trend analysis and performance evaluation.

Closely related is the issue of measurement integrity. Changes to survey content and structure can affect the underlying constructs being measured, potentially leading to inconsistencies in how key concepts are defined and interpreted over time. For example, revisions to telehealth questions or demographic categories may alter the scope or meaning of these variables, making it more difficult to compare results across survey administrations. Without careful validation and documentation, such changes can introduce ambiguity into the data, reducing its reliability and limiting its usefulness for both internal and external stakeholders. Ensuring that measurement constructs remain stable—or that any changes are clearly understood and accounted for—is critical to preserving the survey's analytical value.

The proposed expansion of oversampling flexibility raises additional concerns. While oversampling can be a useful tool for ensuring adequate representation of specific populations, it also introduces the potential for distorted comparisons if not properly controlled. Differences in sampling strategies across plans or regions can affect survey results, particularly if weighting methodologies are not transparent or consistently applied. Moreover, expanded discretion in oversampling could create opportunities for gaming or unintended bias, as entities may have incentives to structure sampling in ways that improve reported outcomes. To mitigate these risks, clear guardrails and disclosure requirements are necessary to ensure that oversampling practices do not compromise the comparability or integrity of the data.

CMS asserts that the proposed changes will reduce respondent burden, but this claim warrants closer scrutiny. While the introduction of gate questions may reduce the number of follow-up items for some respondents, the overall survey process includes additional outreach efforts, including a third email reminder and an extended telephone contact period. These changes may increase the total number of interactions between survey administrators and respondents, potentially offsetting any reductions in survey length. Additionally, the implementation of revised survey instruments may impose transition costs on plans and vendors, including updates to systems, training, and quality control processes. A comprehensive assessment of burden should account for these factors, rather than focusing solely on the number of survey questions.

Increased outreach efforts also raise the issue of survey fatigue. As respondents are contacted more frequently through multiple channels, there is a risk that response quality may decline, even

if response rates increase. Repeated contacts can lead to disengagement, rushed responses, or selective participation, all of which can introduce nonresponse bias and reduce the reliability of the data. Survey fatigue is a well-documented phenomenon in survey research, and its effects can be particularly pronounced in populations that are already subject to multiple data collection efforts. CMS should carefully evaluate whether the marginal gains in response rates justify the potential tradeoffs in data quality.

Another important consideration is the expansion of the survey's use beyond its original consumer-facing purpose. While the survey was initially designed to provide information to help consumers compare plans, it is now also used for regulatory oversight, accreditation, and performance evaluation. This expansion of use increases the stakes associated with survey results and may amplify the consequences of measurement error or bias. When data are used for multiple purposes, particularly those with financial or regulatory implications, it becomes even more important to ensure that the underlying methodology is robust and that limitations are clearly understood. Absent such safeguards, there is a risk that the survey will be used in ways that exceed its design capabilities.

To address these concerns, CRF recommends that CMS adopt enhanced methodological transparency requirements. Specifically, CMS should provide detailed documentation of all proposed changes to the survey instrument and administration, including the rationale for each change, the expected impact on data collection and analysis, and any steps taken to preserve comparability with prior survey administrations. Where feasible, CMS should conduct and publish impact analyses that assess how proposed changes may affect key metrics. This level of transparency is essential to enabling stakeholders to understand and evaluate the implications of survey modifications.

CRF also recommends the establishment of stability requirements governing the frequency and scope of survey revisions. While periodic updates may be necessary to reflect evolving program priorities or external standards, frequent or substantial changes can undermine the survey's value as a longitudinal tool. CMS should consider implementing guidelines that limit the frequency of major revisions and encourage the use of pilot testing or phased implementation for significant changes. By promoting stability, CMS can enhance the reliability of the data and support more meaningful comparisons over time.

With respect to oversampling, CMS should define clear parameters and disclosure requirements to ensure that sampling practices are consistent, transparent, and analytically sound. This should include guidance on acceptable oversampling strategies, standardized weighting methodologies, and requirements for reporting sampling approaches in a manner that allows for independent evaluation. Establishing these guardrails will help mitigate the risk of bias and ensure that survey results remain comparable across plans and populations.

Finally, CRF recommends reforming the approach to burden accounting for the QHP Enrollee Experience Survey. Burden estimates should reflect the full lifecycle costs associated with survey implementation, including instrument redesign, system updates, vendor coordination, training, and ongoing administration. By adopting a more comprehensive approach to burden

assessment, CMS can better align its estimates with real-world impacts and make more informed decisions regarding the design and scope of the survey.

In sum, the QHP Enrollee Experience Survey remains a valuable tool for advancing transparency, supporting consumer choice, and informing program oversight. However, its effectiveness depends on the extent to which it is designed and implemented in a disciplined, stable, and transparent manner. By addressing the concerns outlined above and adopting the recommended guardrails, CMS can enhance the survey's utility while minimizing unintended consequences and ensuring that it continues to serve its intended purposes effectively.

III. CMS–R–284: T-MSIS

The Transformed Medicaid Statistical Information System (T-MSIS) data collection (CMS–R–284) occupies a uniquely important position within the federal healthcare data architecture. As a comprehensive, national-level dataset maintained by the Centers for Medicare & Medicaid Services, T-MSIS serves as the primary repository for information on Medicaid and CHIP enrollment, utilization, and expenditures. Its scale, scope, and integration into federal and state program administration make it a foundational element of policy analysis and decision-making. Accordingly, changes to the structure, content, or governance of T-MSIS have implications that extend well beyond data collection, influencing how policymakers, analysts, and stakeholders understand and evaluate the performance of Medicaid and CHIP programs.

T-MSIS data are used extensively as the basis for policy analysis and actuarial projections. Federal and state officials rely on these data to assess program trends, estimate future costs, and inform legislative and regulatory initiatives. Researchers and external stakeholders also depend on T-MSIS to evaluate program outcomes and identify areas for improvement. Because of this central role, the integrity, consistency, and clarity of T-MSIS data are critical. Any changes to the dataset must be evaluated not only in terms of their immediate administrative impact but also in terms of their effects on downstream analytical uses. Even incremental modifications can influence projections, alter baseline assumptions, and affect the interpretation of program performance.

A key insight in evaluating T-MSIS is that the structure of the data itself shapes the conclusions that can be drawn from it. The selection of data fields, the definitions applied to those fields, and the relationships among them all influence how analysts interpret program dynamics. In this sense, data architecture is not neutral—it embeds assumptions and priorities that can affect policy outcomes. For example, the inclusion or exclusion of specific identifiers can enable or constrain certain types of analysis, while changes to data definitions can shift how trends are measured over time. Recognizing this dynamic is essential to ensuring that modifications to T-MSIS are made deliberately, with a clear understanding of their analytical implications.

CMS proposes several updates to the T-MSIS data collection, including the addition of new data elements such as identifiers related to beneficiary status and program participation. While such additions may be justified in certain contexts, they raise important questions regarding necessity and scope. Each new data field imposes additional reporting requirements on states and increases

the complexity of data management. Absent a clearly articulated use case, the expansion of data collection risks introducing unnecessary burden without delivering commensurate benefits. It is therefore critical that CMS provide explicit justification for each new identifier, including how it will be used, why existing data are insufficient, and how it aligns with statutory and programmatic objectives.

The proposed removal of certain data elements, including those related to sexual orientation and gender identity (SOGI), presents a different but equally important set of considerations. Changes of this nature can affect the continuity of the dataset and complicate longitudinal analyses. When data elements are removed, analysts may lose the ability to track trends over time or to compare results across periods. This can introduce gaps in the data and limit the ability to evaluate program performance in a consistent manner. Accordingly, decisions to remove data elements should be accompanied by a clear explanation of the rationale, as well as an assessment of the impact on existing analytical frameworks and reporting capabilities.

CMS asserts that the proposed updates to T-MSIS will not result in any change in reporting burden. This assertion warrants careful examination. While the formal burden estimate may remain unchanged, the practical impact on states may be more substantial. The addition of new data elements, even if offset by the removal of others, can require updates to state information systems, modifications to data collection processes, and additional validation and quality assurance efforts. These activities involve time, resources, and coordination across multiple stakeholders. As a result, the claim of "no burden change" may not fully capture the operational realities faced by states, particularly in the near term as systems are adapted to accommodate the revised requirements.

The federal-state dynamic inherent in T-MSIS further amplifies these concerns. While CMS establishes the data requirements, states are responsible for collecting, validating, and submitting the data. This effectively shifts the burden of implementation to state agencies, which must absorb the costs associated with system changes and ongoing compliance. States vary in their technical capacity and resource availability, and changes to T-MSIS can have uneven impacts across jurisdictions. A disciplined approach to data collection must therefore take into account not only the federal perspective but also the practical implications for state partners, ensuring that requirements are feasible, proportionate, and supported by adequate guidance and resources.

To address these issues, CRF recommends that CMS adopt a defined use-case framework for T-MSIS data elements. Under this approach, each data field included in the collection should be linked to a specific, clearly articulated purpose, whether related to program administration, statutory reporting, or analytical needs. This framework should distinguish between primary uses, which are essential to the operation of the program, and secondary uses, which may be beneficial but are not strictly necessary. By requiring explicit justification for each data element, CMS can ensure that the scope of the collection remains targeted and aligned with its core objectives.

In addition, CRF recommends that CMS implement a process for periodic review and reassessment of T-MSIS data elements. Such reviews should evaluate the continued necessity and utility of each field, with a willingness to sunset or modify elements that no longer serve a

meaningful function. This process should be transparent and involve input from state partners and other stakeholders. Regular reassessment will help prevent the accumulation of unnecessary data requirements and support a more dynamic, responsive approach to data governance.

T-MSIS is an indispensable tool for understanding and managing Medicaid and CHIP programs, but its effectiveness depends on disciplined data governance. Expanding the dataset without clear purpose, underestimating the burden on states, or failing to maintain continuity over time can undermine its value. By emphasizing data minimization, clearly defined use cases, and ongoing reassessment, CMS can strengthen the integrity and utility of T-MSIS while ensuring that it remains a sustainable and effective component of the nation's healthcare data infrastructure.

IV. CMS–10407: SUMMARY OF BENEFITS AND COVERAGE

The Summary of Benefits and Coverage (SBC) and Uniform Glossary requirements (CMS–10407) remain an important component of the consumer information framework administered by the Centers for Medicare & Medicaid Services. These requirements were developed to improve transparency in health coverage by providing standardized information about plan benefits, cost-sharing obligations, and key terms. CRF recognizes the importance of this objective and supports efforts to ensure that consumers have access to clear, consistent information when evaluating health coverage options. At the same time, the effectiveness of the SBC framework depends not only on the availability of information, but on its usability and its impact on real-world decision-making.

The central purpose of the SBC is to enable consumers to compare health plans in a meaningful and informed manner. By standardizing the format and content of disclosures, CMS seeks to reduce complexity and facilitate side-by-side evaluation of coverage options. In theory, this approach should enhance consumer understanding and support more efficient market outcomes. However, the degree to which standardized disclosures achieve these goals depends on how consumers interact with the information provided. Standardization alone does not guarantee that the information is accessible, comprehensible, or actionable for the intended audience.

A critical insight in evaluating the SBC framework is that standardization is not synonymous with usability. While uniform formats can reduce variation across plans, they do not necessarily address the underlying challenges that consumers face in interpreting complex health insurance information. If disclosures are overly dense, technical, or disconnected from the decision-making context, consumers may struggle to extract meaningful insights, regardless of how consistently the information is presented. In such cases, the result may be formal compliance with disclosure requirements without a corresponding improvement in consumer understanding or behavior.

This dynamic raises important questions about the relationship between burden and benefit. The SBC requirements impose significant compliance obligations on issuers and plan sponsors, including the need to generate standardized documents, update them in response to plan changes, and distribute them to consumers in a timely manner. These activities involve administrative, operational, and technological costs that are not insignificant. At the same time, the marginal benefit of additional standardization—particularly in the absence of demonstrated improvements

in consumer comprehension—may be limited. A disciplined PRA analysis should therefore examine whether the incremental benefits of maintaining and updating these requirements justify the ongoing burden imposed on regulated entities.

Empirical and behavioral evidence suggests that consumers do not consistently utilize standardized disclosures in the manner envisioned by policymakers. Many consumers rely on simplified heuristics, recommendations, or prior experience when selecting health coverage, rather than conducting detailed comparisons of plan documents. Even when SBC materials are available, they may not be fully read or understood, particularly if they are perceived as complex or time-consuming to review. This reality does not negate the value of transparency, but it does suggest that the current approach may not fully align with how consumers actually make decisions. As a result, there is a risk that the SBC framework emphasizes form over function, prioritizing compliance with disclosure requirements over meaningful engagement.

In light of these considerations, CRF recommends that CMS place greater emphasis on simplification, readability, and real-world usability in the design and implementation of SBC requirements. This includes exploring opportunities to streamline content, reduce redundancy, and present information in a manner that is more intuitive for consumers. CMS should also consider incorporating user-centered design principles and conducting empirical testing to evaluate how consumers interact with SBC materials in practice. Such testing can provide valuable insights into which elements are most useful and which may be unnecessary or counterproductive. By focusing on how information is actually used, rather than how it is theoretically structured, CMS can enhance the effectiveness of the SBC framework.

Ultimately, the continued success of the SBC requirements depends on their ability to deliver meaningful value to consumers while maintaining a reasonable balance between burden and benefit. As CMS moves forward with this information collection, it should take the opportunity to reassess the effectiveness of the current framework and to consider whether adjustments are needed to better align with real-world behavior and program objectives. A more targeted, user-focused approach—grounded in evidence and responsive to stakeholder input—can help ensure that the SBC continues to serve its intended purpose without imposing unnecessary or disproportionate burdens.

CONCLUSION

CRF appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services on the proposed information collections under the Paperwork Reduction Act. The PRA process serves as an important mechanism for ensuring that federal data collection activities remain transparent, justified, and subject to meaningful stakeholder input. Engagement at this stage is particularly valuable given the central role that information collection plays in the administration of federal healthcare programs and the increasing reliance on data-driven frameworks to guide policy and operational decisions.

CRF strongly supports the use of data to inform policymaking, improve program performance, and enhance transparency for consumers and stakeholders. Well-designed information

collections can provide critical insights into program operations, support more effective oversight, and enable more informed decision-making across the healthcare system. At the same time, the value of data-driven policymaking depends on the quality, relevance, and integrity of the underlying data, as well as the extent to which data collection efforts are aligned with clearly defined objectives. Ensuring that information collections meet these standards is essential to realizing their full potential.

A central theme of these comments is that the design of information collections ultimately determines their value. The selection of data elements, the structure of collection instruments, and the methodologies used to gather and interpret data all influence the utility of the resulting information. Thoughtful design can enhance comparability, improve accuracy, and support meaningful analysis, while poorly calibrated approaches can introduce bias, create unnecessary complexity, and limit the usefulness of the data. As CMS continues to refine its information collection activities, careful attention to design considerations will be critical to ensuring that these efforts produce reliable and actionable insights.

At the same time, CRF remains concerned about the potential for the expansion of information collection activities without sufficient discipline or clear limiting principles. As collections evolve over time, there is a tendency to add new data elements, expand use cases, and increase reporting requirements, often without a comprehensive reassessment of necessity and burden. This incremental growth can result in cumulative burdens that are disproportionate to the benefits achieved, particularly when data are collected for purposes that are not clearly defined or are only marginally related to core program functions. Addressing this dynamic requires a more deliberate and structured approach to managing the scope of information collections.

The importance of these issues extends beyond individual collections to the broader healthcare system. Data collected by CMS play a significant role in shaping market behavior, informing policy decisions, and influencing cost structures across federal healthcare programs. They affect how plans compete, how providers deliver care, and how resources are allocated. As such, the design and implementation of information collections have system-level implications that warrant careful consideration. Ensuring that these collections are efficient, targeted, and analytically sound is essential to maintaining the integrity and effectiveness of the programs they support.

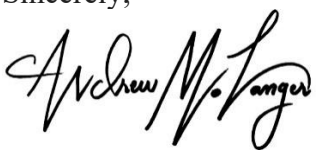
Looking forward, CRF encourages CMS to adopt an approach to information collection that emphasizes calibration, transparency, and restraint. Calibration requires aligning the scope and detail of data collection with clearly defined purposes and demonstrated utility. Transparency involves providing clear documentation of methodologies, assumptions, and changes to collection instruments, enabling stakeholders to understand and evaluate the data. Restraint entails exercising discipline in expanding data requirements and being willing to streamline or eliminate elements that no longer serve a meaningful function. Together, these principles can help ensure that information collection activities remain both effective and sustainable.

In sum, the continued modernization of CMS data systems presents an opportunity to enhance program performance and improve outcomes for beneficiaries. Realizing this opportunity will depend on the extent to which modernization efforts are guided by disciplined design and

grounded in a clear understanding of both benefits and costs. By incorporating the recommendations outlined in these comments, CMS can strengthen the analytical foundation of its information collection activities while reducing unnecessary burden and preserving flexibility for future innovation.

The effectiveness of CMS's information collection activities will not be determined by the volume of data collected or the breadth of reporting requirements imposed, but by whether those collections are designed and implemented in a manner that is analytically rigorous, operationally efficient, and appropriately bounded to serve clearly defined statutory and programmatic objectives.

Sincerely,



Andrew M. Langer
Director
CPAC Foundation Center for Regulatory Freedom

PUBLIC SUBMISSION

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Comment On: CMS-2026-0595-0001
Agency Information Collection Activities; Proposals, Submissions, and Approvals

Document: CMS-2026-0595-DRAFT-0004
Comment on CMS-2026-0595-0001

Submitter Information

Name: Christian Price
Address:
Maitland, FL, 32754

General Comment

I’m believe it is fair for information to be collected so long as it is stated openly and done fairly.

PUBLIC SUBMISSION

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Comment on CMS-2026-0595-0001

Submitter Information

Name: Nakul Karkare
Address:
Stony Brook, NY, 11790
Email: office@cortho.org
Phone: 6319812663

General Comment

T-MSIS is described as the only national-level source for Medicaid utilization data, enrollment, expenditures, and actuarial forecasting. The QHP Enrollee Survey aims to produce comparable, actionable performance data across competing health plans. Both goals rest on a foundation that is structurally compromised: procedure coding that permits two clinicians performing the same service to submit different codes — legitimately.

When the underlying procedural data is inconsistent, no downstream analysis — utilization trends, expenditure modeling, cross-plan comparisons, fraud detection — can be fully trusted. The noise is baked in at the source.

I have developed a deterministic procedure coding system that eliminates this variability entirely. Every code derives automatically from data elements already present in the claim. No clinician discretion. No ambiguity. Same service, same documentation, same code — across every provider, every payer, every setting. Every component is fully auditable and traceable to its source.

This system is complete, tested, and available without licensing fees. It is directly applicable to improving the integrity of both T-MSIS data and QHP comparative analytics.

Nakul Karkare MD
https://www.newyorkhipknee.com/
https://www.cortho.org

August 13, 2026

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Submitted Electronically: https://www.reginfo.gov/public/do/PRAMain

Re: Consumer Experience Survey Data Collection

Dear Sir/Madam:

UnitedHealthcare (UHC) is pleased to submit comments to the Centers for Medicare & Medicaid Services (CMS) in response to the information collection request for the Consumer Experience Survey Data Collection (91 FR 43093).

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience, and delivering access to high-quality care. UnitedHealthcare is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes, and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that improves outcomes and lessens the burden of disease.

Overall, UHC is supportive of the enhancements CMS is planning for the QRS and QHP Enrollee Experience Survey, especially those that would reduce burden on enrollees and streamline their ability to respond. In what follows, we offer technical input on operational impacts related to proposed changes to the telephone survey protocol, considerations around modifications to the QRS scoring methodology, and additional questions for future updates to the survey questionnaire, among other recommendations.

Proposed Removal of Tobacco-Usage Questions

CMS proposes to remove four questions related to tobacco-usage which are used to calculate the Medical Assistance with Smoking and Tobacco Use Cessation measure, and to instead transition to collecting this information through digital quality measures.

UHC supports CMS's proposal to remove the four tobacco-usage questions used to calculate the Medical Assistance with Smoking and Tobacco Use Cessation measure beginning with the 2027 survey administration, consistent with NCQA's retirement of the underlying measure and its move toward an electronic clinical data–based replacement rather than self-reporting. This change may reduce respondent burden while keeping the QHP Enrollee Survey aligned with the broader measures landscape.

Revising Race/Ethnicity Questions to Align With Federal Standards

CMS proposes to revise the current race and ethnicity questions to align with federal standards. UHC supports combining the current two separate race and ethnicity questions into one single question as proposed in this Consumer Experience Survey Data Collection.

Revisions to the QHP Enrollee Survey Questionnaire and Materials

CMS proposes adding five screener questions that would allow respondents to skip follow up questions that do not apply to them (customer service contact, forms, access to a personal doctor, test ordering, specialist visits).

UHC supports the overall intent to reduce respondent burden through clearer logic and improved routing. The current survey already incorporates logic embedded within response options; moving routing eligibility into standalone screener questions may make survey flow cleaner—particularly for telephone administration—and may reduce the awkwardness of asking respondents to evaluate experiences they did not have.

UHC also recommends that CMS monitor how these changes affect denominators for impacted items, given potential implications for year over year comparability.

Modifications to the Telephone Protocol of the QHP Enrollee Survey

CMS proposes refinements to the survey fielding protocol to improve response rates, including extending the telephone follow-up window (from 19 to 25 calendar days), initiating telephone calls to nonrespondents earlier (beginning on Day 48 rather than Day 55), and adding a third email reminder (on Day 40).
UHC supports efforts to improve response rates and agrees that refinements to outreach strategy may be helpful. At the same time, we recommend CMS carefully consider operational effects of beginning calls earlier in the fielding timeline.

Starting calls earlier may increase the apparent nonrespondent pool at the point of first dial, because a shorter period of mail and web collection may mean more sampled enrollees still appear as nonrespondents when calls begin. Slower postal delivery and mail processing timelines may result in situations where an enrollee returns a completed survey, but it has not yet been received and logged by the vendor—creating a risk that vendors call individuals who have already responded. This may be a poor respondent experience and operational inefficiency. If earlier calling increases call volume without a proportional increase in completed surveys, it may also increase administration costs over time.

In addition, UHC supports the proposal to add a third email reminder on Day 40. Email is a lower cost touchpoint than telephone, and a Day 40 reminder is an outreach that may convert some potential phone respondents before the telephone phase begins, partially offsetting the call volume concerns noted above.

Oversampling

CMS proposes to update the QHP Enrollee Survey sampling protocol to allow oversampling at any level. UHC supports CMS's proposal to update the QHP Enrollee Survey sampling protocol to allow oversampling at any level. Given the length and complexity of the survey, achieving adequate response volumes can be challenging. Providing health plans with greater flexibility to increase sample sizes will help mitigate low response rates and support the collection of higher rates of completed surveys. This approach can enhance the reliability and stability of survey results by ensuring a broader representation of member experiences, while also reducing the impact of nonresponse bias. Ultimately, allowing oversampling at any level will strengthen the value of the survey data used to assess plan performance and inform quality improvement efforts. To support comparability and validity across

issuers and markets, UHC further recommends that CMS continue applying appropriate weighting and methodological safeguards when implementing expanded oversampling flexibility.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Nicole Brady, MD, MBA
Chief Medical Officer & Vice President Individual & Specialty
UnitedHealthcare Employer & Individual