United States Government Accountability Office

Report to Congressional Committees

September 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist

Accessible Version

GAO-16-761

GAO Highlights

Highlights of GAO-16-761, a report to congressional committees

September 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist

Why GAO Did This Study

The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, included provisions that were intended to make health insurance more available and affordable for individuals seeking coverage, including the establishment of health insurance exchanges. Health insurance was made available to individuals through the exchanges beginning in 2014. While PPACA contributed to an overall expansion in health insurance coverage, experts and consumer advocates have raised concerns about enrollees' experiences with QHPs, including access to providers and affordability of care.

PPACA includes a provision for GAO to conduct an examination of exchange activities and QHP enrollees. This report describes (1) what is known about enrollee experiences with QHPs obtained through the exchanges during the first years of exchange operation, and (2) how CMS and selected states have monitored the post-enrollment experiences of those who obtained their QHPs through the exchanges. GAO examined federal and state laws, regulations, and reports, and conducted a literature review to identify original research on enrollees' experiences with QHPs obtained through the exchanges. GAO interviewed officials from CMS and five selected states—Colorado, Indiana, Montana, North Carolina, and Vermont—that varied in geography and whether the state or CMS operated the exchange on which QHPs were offered, as well as officials from stakeholder groups and consumer assisters.

View GAO-16-761. For more information, contact John Dicken at (202)512-7114 or dickenj@gao.gov

What GAO Found

Available survey data show that most enrollees who obtained their coverage through the health insurance exchanges were satisfied overall with their qualified health plans (QHP) during the first few years that exchanges operated, according to five national surveys of QHP enrollees that GAO identified through its literature review. Specifically, most QHP enrollees who obtained their coverage through the exchanges reported overall satisfaction with their plans in 2014 through 2016, according to three national surveys. The surveys reported that QHP enrollees' satisfaction with their plans was either somewhat lower than or was similar to that of those enrolled in employer-sponsored health insurance in 2015 and 2016. To varying degrees, QHP enrollees expressed satisfaction with specific aspects of their plan, including their coverage and choice of providers, and plan affordability. Stakeholders—including experts, state departments of insurance, and others GAO interviewed—and literature GAO reviewed also revealed some concerns about QHP enrollee experiences. Some enrollees found it too expensive to pay for their out-of-pocket expenses before reaching their deductibles and have reported concerns about affording care or have been deterred from seeking care, according to experts. Some enrollees have faced difficulties understanding their QHP's coverage terminology and others have faced problems accessing care after enrollment, according to stakeholders and literature reviewed. These issues have also been identified in literature as longstanding concerns of the private health insurance market.

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), and selected states GAO reviewed have monitored enrollees' post-enrollment experiences by reviewing information reported by consumers and consumer assisters. For example, CMS uses information collected from enrollees through its Marketplace Call Center—where exchange enrollees may call to request agency assistance in resolving concerns. CMS officials said that they use this information to identify trends in enrollees' post-enrollment experiences and ensure that enrollee concerns are resolved in a timely manner. They began using it in 2016 to identify issuers for compliance reviews. Similarly, officials from the five selected states' departments of insurance reported tracking consumer complaints by issuer and working to resolve all reported issues. CMS developed a survey that was administered to a sample of QHP enrollees nationwide in 2015 and 2016, to gather information about their experiences with their plans. According to CMS officials, the agency expects to use results of its 2017 and future surveys to inform its monitoring of issuers. In addition, QHP enrollees in Vermont were surveyed with respect to their satisfaction in 2015; state officials reported using the results to inform their prioritization of work. CMS and selected states also reported monitoring enrollee experiences with information received from consumer assisters—including navigators—who interact directly with QHP enrollees. CMS officials told GAO that they have used information received from federally funded navigators to troubleshoot enrollee problems, clarify policies, or develop additional training or materials for dissemination.

HHS provided technical comments on a draft of this report, which were incorporated as appropriate.

Contents

Letter 1

Background 4
Available Data Show Early QHP Enrollee Satisfaction Despite Some Concerns 7
CMS and Selected States Have Monitored Post-Enrollment Experiences by Reviewing Information Reported by Consumers and Assisters 24
Agency Comments 30

Appendix I: Methodology Information for Literature Review and Five National Surveys 33

Appendix II: CMS and Selected States' Oversight of Qualified Health Plans 37

Appendix III: CMS Exchange Consumer Casework Data for 2015 42

Appendix IV: GAO Contact and Staff Acknowledgments 47

Tables

Table 1: National Survey Data on Enrollee Satisfaction with Qualified Health Plans (QHP) Obtained through the Exchanges, 2014 through 2016 8
Table 2: Examples of National Survey Data on Qualified Health Plan (QHP) Enrollee Satisfaction with Choice of Providers, 2015 or 2016, among Those Obtaining Coverage through the Exchanges 11
Table 3: Examples of National Survey Data on Qualified Health Plan (QHP) Enrollee Satisfaction with Plan Affordability, 2015 or 2016, among those Obtaining Coverage through the Exchanges 14
Table 4: Summary of Centers for Medicare & Medicaid Services (CMS) Exchange Casework, 2014-2015 25
Table 5: Key Methodological Information for Nationally Representative Surveys of Qualified Health Plan (QHP) Enrollees, among those Obtaining Coverage through the Exchanges 34
Table 6: Summary of Centers for Medicare & Medicaid Services (CMS) Post-Certification Reviews Conducted in States Using the Federally Facilitated Exchange, 2014-2016 38

Table 7: Centers for Medicare & Medicaid Services (CMS) Exchange Consumer Casework by Category and Subcategory in 2015 44

Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plan
SBE	state-based exchange

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

September 12, 2016

Congressional Committees

The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, included provisions that were intended to make health insurance more available and affordable for individuals seeking coverage.[1] Among these provisions, PPACA required the establishment of health insurance exchanges—marketplaces where eligible individuals may compare and select among qualified health plans (QHP) offered by participating private issuers.[2] PPACA directed each state to establish an exchange itself—referred to as a state-based exchange (SBE)—or cede the responsibility to the Department of Health and Human Services (HHS) to establish the exchange—referred to as a federally facilitated exchange (FFE).[3] Health insurance was made available through the exchanges beginning January 1, 2014. HHS's Centers for Medicare & Medicaid Services (CMS) and states each play a role in overseeing the exchanges, including the oversight of QHPs. For example, CMS has direct oversight responsibilities for all exchanges, as CMS is responsible for certifying SBEs for operation and also directly operates the FFE, including by ensuring plan and issuer compliance with exchange requirements. In addition, state departments of insurance retain responsibility for overseeing health insurance plans, including QHPs, sold in their state.

We previously reported that federal subsidies available through PPACA for purchasing a QHP likely contributed to an expansion of health

[1]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereafter, "PPACA"). In this report, references to PPACA include any amendments made by HCERA.

[2]An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

[3]From 2014 through 2016, 17 states operated an SBE, and 34 states used the FFE. The term "state" in this report includes the District of Columbia. HHS's Centers for Medicare & Medicaid Services (CMS), which is tasked with overseeing the establishment of exchanges, refers to exchanges as marketplaces.

insurance coverage.[4] However, experts and consumer advocates have raised questions about enrollees' experiences with QHPs, including access to providers and affordability of care.[5] PPACA includes a provision for us to conduct an examination of exchange activities, including the experiences of enrollees in QHPs obtained through the exchanges.[6] In this report, we describe:

1. what is known about the experiences of enrollees in QHPs obtained through the exchanges during the first years of exchange operation; and
2. how CMS and selected states have monitored the post-enrollment experience of those who obtained their QHPs through the exchanges.

To describe what is known about the experiences of enrollees in QHPs obtained through the exchanges during the first years of exchange operation, we performed a search of research databases to identify any literature published from January 1, 2014, through April 30, 2016, that reported original research on QHP enrollees' overall satisfaction, perceptions of affordability, and experience accessing care.[7] Through this process, we identified and reviewed the results of five national surveys of QHP enrollees who obtained their coverage through the exchanges; the surveys were administered between 2014 and 2016. To assess the reliability of the data presented from these surveys, we interviewed or corresponded with the authors of all of the survey reports, reviewed supporting documentation to understand what the surveys measured, and we examined the data for apparent errors. Although these surveys had relatively low response rates, all reported that their results are nationally generalizable within certain margins of sampling error. In addition, the surveys each reported similar results with respect to enrollee

[4]GAO, *Private Health Insurance: Early Evidence Finds Premium Tax Credit Likely Contributed to Expanded Coverage, but Some Lack Access to Affordable Plans*, GAO-15-312 (Washington, D.C.: Mar. 23, 2015).

[5]For the purposes of this report, we use the term "consumer" to refer to those who are in the process of selecting a plan as well as those who have enrolled.

[6]42 U.S.C. § 18033(b).

[7]While QHPs may also be purchased outside of the exchanges, in this report, the term "QHP enrollees" refers to those who have obtained their QHP coverage through the exchanges.

experiences. Thus, we found the data to be sufficiently reliable for our purposes. (Appendix I provides more detailed information about our literature review and the five national surveys.) We also reviewed journal articles, working papers, and government publications, that presented original research on QHP enrollees' experiences with their plans after their enrollment, including those reporting on enrollee cost-sharing and provider network adequacy that we identified through our literature review. We interviewed officials from CMS and five states—Colorado, Indiana, Montana, North Carolina, Vermont—about their knowledge of QHP enrollees' experiences. We selected the five states to obtain diversity in geography as well as exchange type. Colorado and Vermont each administered an SBE, and Indiana, Montana, and North Carolina used the FFE, for the 2014 through 2016 plan years. We interviewed officials from each state's department of insurance and from Colorado's and Vermont's exchange offices, as well as assisters—federal or state-funded individuals who, among other things, help QHP enrollees with addressing post-enrollment issues—from each of the five selected states.[8] We also interviewed experts and industry officials, including those from the National Association of Insurance Commissioners, to obtain a broad perspective about enrollee experiences with QHPs.

To describe how CMS and selected states have monitored the post-enrollment experience of those who obtained their QHPs through the exchanges, we reviewed relevant federal and state documents, including laws, regulations, guidance, and reports, and examined CMS data on the number and type of exchange-related issues that consumers raised to the agency in 2014 and 2015. To assess the reliability of these data, we interviewed CMS officials and reviewed supporting documentation. We found the data to be sufficiently reliable for our purposes. We also interviewed knowledgeable officials from CMS and the five selected states, including state department of insurance officials, exchange officials, and assisters.

[8]Specifically, we interviewed officials from federally funded assister programs at Affiliated Service Providers of Indiana Inc., Intermountain Planned Parenthood, Inc. (Montana), and Legal Aid of North Carolina, as well as other assisters at Community Health Centers of Burlington (Vermont), the Health District of Northern Larimer County (Colorado) and the Montana Primary Care Association.

We conducted this performance audit from August 2015 to September 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS and State Oversight of QHPs

CMS and states share responsibilities for overseeing QHPs offered through the exchanges. Specifically, CMS is responsible for establishing minimum QHP certification standards that all QHPs must meet in order to participate in any exchange. Federal regulations require that all exchanges have procedures to certify QHPs annually to ensure compliance with federal requirements. To be certified as a QHP, a plan must meet certain minimum federal requirements, including those related to, for example, the coverage of certain benefits and limits on cost-sharing.[9] In FFE states, CMS is responsible for overseeing compliance with these requirements; in states operating SBEs, the states are responsible for ensuring that plans comply.[10] CMS is responsible for conducting oversight and monitoring of QHPs offered on the FFE, and also requires all SBEs to develop an oversight and monitoring program.[11]

In addition to meeting federal exchange-specific requirements, QHP issuers must also abide by state-specific insurance regulations that apply to all issuers offering health insurance products, as states are the primary

[9]For example, all QHPs are required to offer a core package of health care services, known as essential health benefits, which include coverage of emergency services, hospitalization, maternity and newborn care, and preventive services, among others. PPACA also limits the amount of cost-sharing a QHP may impose for such benefits. 42 U.S.C. § 18022.

[10]Some states that elected not to establish a state-based exchange entered into a partnership with HHS's CMS in which HHS establishes and operates the exchange while states assist HHS in carrying out certain functions of the exchange. Because a partnership exchange is a variation of an FFE, we include partnership states as FFE states in this report.

[11]45 C.F.R. § 155.1010 (2015).

regulators of health insurance. Specifically, all QHPs, whether offered on the FFE or SBE, must be offered by a health insurance issuer that is licensed and in good standing to offer insurance coverage in each state in which it offers QHPs. As a result, QHP issuers are subject to oversight by the states in which they offer QHPs. As part of this oversight, state departments of insurance manage complaint hotlines where enrollees can notify agencies of concerns related to any health insurance plan sold in that state, including QHPs offered on the FFE or an SBE.

Exchange Consumer Assistance Responsibilities

All exchanges are required to carry out certain consumer assistance functions. Specifically, CMS requires exchanges to operate a toll-free call center and website to address the needs of consumers and enrollees requesting assistance and to conduct outreach and educational activities.[12] For example, CMS operates a Marketplace Call Center to assist the needs of consumers in states that utilize the FFE. In addition, all exchanges are required to have a "navigator" program to carry out public education activities, help consumers select a QHP, and offer QHP enrollees with assistance after their enrollment, among other things.[13] CMS awards grants to organizations to serve as navigators for the FFE. All exchanges may also implement other "assister" programs that perform many of the same or similar functions as navigators. Navigators and other assisters are collectively referred to as "assisters."

Financial Assistance for QHP Enrollees through the Exchanges

Individuals purchasing coverage through the exchanges may be eligible to receive financial assistance to offset the cost of such coverage, and, according to CMS, over three-fourths of QHP enrollees obtain at least one form of such assistance. Eligibility for financial assistance is based on income and provided in the form of premium tax credits and cost-sharing subsidies.

[12]45 C.F.R. § 155.205(a) (2015).

[13]42 U.S.C. § 13031(1). Navigators are individuals and entities, such as community and consumer-focused nonprofit groups, to which CMS awards financial assistance to provide health insurance-related information in a fair and impartial manner and to facilitate enrollment in QHPs. Beginning with navigator grants to be awarded in 2018, navigators in the FFE will also be required to provide additional post-enrollment assistance, including with the process of filing eligibility appeals. 81 Fed. Reg. 12204, 12338 (Mar., 8, 2016) (to be codified at 45 C.F.R. § 155.205(e)(9)).

One form of assistance is the premium tax credit, which is generally available to income-eligible individuals who do not have access to health insurance that meets certain standards. The credit is designed to reduce an eligible individual's cost of purchasing health insurance through the exchange and can be paid to an enrollee's issuer in advance to reduce the enrollee's monthly premium costs. The amount of the premium tax credit varies and is designed to provide larger credit amounts to those with lower incomes.[14] QHP enrollees who qualify for and opt to receive advance payments of the premium tax credit based on their income and family size at the time of application must attest that they will file a federal tax return for the applicable plan year. Such enrollees must reconcile on their federal tax return the amount of advance payments received based on their actual reported income and family size for the year.[15] Enrollees who qualify for premium tax credits may also be eligible to receive cost-sharing reduction assistance to help offset QHP enrollees' out-of-pocket expenses, including by lowering their deductibles, coinsurance and co-payments.[16]

[14]Premium tax credits are available to enrollees with incomes of 100 to 400 percent of the federal poverty level. See also GAO-15-312.

[15]45 CFR 155.305(f)(4) (2015).

[16]Specifically, cost-sharing reductions are available to individuals with incomes between 100 and 250 percent of the federal poverty level who are enrolled in certain QHPs.

Available Data Show Early QHP Enrollee Satisfaction Despite Some Concerns

Available Data Show That Most Early QHP Enrollees Expressed Satisfaction with Their Plans

Available data from the five national surveys we identified through our literature review show that most QHP enrollees were satisfied overall with the plans they obtained through the exchanges. QHP enrollees have also expressed satisfaction, to varying degrees, with specific aspects of their plans, including their coverage, their choice of providers, and plan affordability, according to five national surveys we reviewed.

Overall Plan Satisfaction

QHP enrollees who obtained their coverage through the exchanges have reported overall satisfaction with their plans from 2014 through 2016, according to national surveys that we reviewed. Specifically, 65 percent or more of QHP enrollees surveyed expressed overall satisfaction with their plans in 2014 through 2016, according to three national surveys that asked this question of enrollees. (See table 1.)

Table 1: National Survey Data on Enrollee Satisfaction with Qualified Health Plans (QHP) Obtained through the Exchanges, 2014 through 2016

National survey	Survey year	Percent of QHP enrollees reporting satisfaction with their plan
Commonwealth Fund[a]	2016	77
	2015	81
	2014	65
Deloitte[b]	2016	85
	2015	86
PerryUndem[c]	2015	74

Source: GAO. I GAO-16-761

Notes: Data reflect enrollees who reported being somewhat to very satisfied with their QHP. The surveys cannot be compared directly because, for example, each was conducted during different time periods and asked questions and recorded responses slightly differently. Although the surveys had relatively low response rates, all report that their results are nationally generalizable.

[a]The Commonwealth Fund, Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February – April 2016 (New York: May 25, 2016).

[b]Deloitte Center for Health Solutions, 2016 Survey of US Health Care Consumers: A Look at Exchange Consumers (Washington, D.C.: May 11, 2016) Deloitte Center for Health Solutions, Public Health Insurance Exchanges: Opening the Door for a New Generation of Engaged Health Care Consumers, 2015 Survey of US Health Care Consumers (Washington D.C.: Aug. 3, 2015), and additional unpublished data provided by the survey's authors.

[c]PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, Results From a Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace (October 2015).

The overall satisfaction level of QHP enrollees was somewhat lower than or similar to those who were enrolled in employer-sponsored health insurance in 2015 and 2016. Specifically, one national survey reported that 86 percent of QHP enrollees were satisfied or somewhat satisfied with their current health plan in 2015, compared to 93 percent of employer-sponsored health insurance enrollees.[17] The survey did not specifically report the reason for the difference in satisfaction levels. The same survey in 2016 reported that overall plan satisfaction among QHP enrollees was equivalent to those with employer-sponsored health insurance, although other national surveys that we reviewed reported that

[17]Deloitte Center for Health Solutions, *Public Health Insurance Exchanges: Opening the Door for a New Generation of Engaged Health Care Consumers, 2015 Survey of US Health Care Consumers* (Washington, D.C.: Aug. 3, 2015).

QHP enrollees were, for example, less satisfied with their choice of providers or less likely to report ease in affording their premiums, compared to those with employer-sponsored insurance.[18]

Two of the national surveys we reviewed examined QHP re-enrollment, which can provide additional context for QHP enrollees' overall satisfaction with their plans. Specifically, one national survey found that 77 percent of adult QHP enrollees that re-enrolled in the same plan for 2016 reported satisfaction with their QHP.[19] Another national survey of QHP enrollees reported that, in 2015, most—82 percent—of those re-enrolling selected a plan with the same insurance company and about half stayed with the same plan.[20] Stakeholders we interviewed and other literature we reviewed also provided additional context for QHP enrollees' overall satisfaction with their plans based on QHP re-enrollment and a stable volume of consumer complaints regarding health insurance. For example, while many factors, including financial incentives, may affect an enrollee's decision to re-enroll in a plan, officials from one exchange office we interviewed told us that they consider plan re-enrollment as one important measure of QHP enrollee satisfaction because enrollees have the capacity to change QHPs annually. In addition, a statewide survey of Vermont QHP enrollees found that 9 percent of QHP enrollees renewing their coverage in 2015 switched plans, with 80 percent of renewing QHP

[18]Deloitte Center for Health Solutions, *2016 Survey of US Health Care Consumers: A Look at Exchange Consumers* (Washington, D.C.: May 11, 2016), The Commonwealth Fund, *Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015* (New York: Sept. 25, 2015), and Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, Wave2* (Menlo Park, Ca.: May 21, 2015).

[19]The Commonwealth Fund, *Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction; Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016* (New York: July 7, 2016).

[20]Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers*.

enrollees reporting that their plan fit their needs very or somewhat well.[21] Although the remaining four selected states in our review had not directly measured QHP enrollee satisfaction, officials from all of these states' departments of insurance told us that QHP enrollees in their states have not reported significant problems that are unique to QHPs. In addition, department of insurance officials from two of these selected states told us that the volume of complaints they received for all health plans had not increased since health insurance became available through the exchanges in 2014.

Coverage and Choice of Providers

QHP enrollees who obtained their coverage through the exchanges have rated their health insurance coverage positively and generally expressed satisfaction with their choice of providers, according to national surveys we reviewed. Specifically, two national surveys reported that approximately 70 percent of QHP enrollees rated their health insurance coverage as good, very good, or excellent in 2016.[22]

QHP enrollees have also generally reported satisfaction with their choice of providers, according to four national surveys we reviewed. For example, one national survey reported that 74 percent of QHP enrollees noted satisfaction with their choice of primary care doctor in 2016, and a smaller portion of enrollees—59 percent—noted satisfaction with their choice of specialists. Two other national surveys reported that more than 75 percent of QHP enrollees surveyed were satisfied with the doctors

[21]This survey was conducted by the University of Massachusetts Medical School from April to June 2015 and achieved an overall 43 percent response rate, which included 1,900 QHP enrollees (1,410 of which re-enrolled in a QHP in 2015) as well as 669 Medicaid enrollees. The margin of sampling error for the exchange population was +/- 2.5 percentage points. Survey documentation indicates that results are representative at the state level. Vermont Health Connect, *Customer Satisfaction and Experience Evaluation, Spring 2015 Survey of QHP & Medicaid Customers*, Prepared by University of Massachusetts Medical School, Center for Health Policy and Research, (Shrewsbury, Ma.: September 2015).

[22]Kaiser Family Foundation *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Menlo Park, CA: May 20, 2016), and The Commonwealth Fund, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February – April 2016* (New York: May 25, 2016).

included under their plan.[23] The fourth national survey reported levels of dissatisfaction, stating that 14 percent of QHP enrollees reported dissatisfaction with their choice of doctors and other providers.[24] (See table 2.)

Table 2: Examples of National Survey Data on Qualified Health Plan (QHP) Enrollee Satisfaction with Choice of Providers, 2015 or 2016, among Those Obtaining Coverage through the Exchanges

National survey	Survey year	Percent of QHP enrollees reporting
Commonwealth Fund[a]	2016	• Satisfaction with doctors covered: 78 percent[b]
Kaiser Family Foundation[c]	2016	• Satisfaction with choice of primary care provider: 74 percent • Satisfaction with choice of hospitals: 75 percent • Satisfaction with choice of specialists: 59 percent
PerryUndem[d]	2015	• Satisfaction with doctors and services covered: 81 percent
Urban Institute[e]	2015	• Dissatisfaction with choice of doctors and other providers: 14 percent[f]

Source: GAO. I GAO-16-761

Notes: The table presents the most recently available data as of July 2016. Data reflect enrollees who reported being somewhat to very satisfied, or somewhat to very dissatisfied, as noted. The surveys cannot be compared directly because, for example, each was conducted during different time periods and asked questions and recorded responses slightly differently. Although the surveys had relatively low response rates, all report that their results are nationally generalizable.

[a]The Commonwealth Fund, Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction; Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016 (New York: July 7, 2016).

[b]Data reflect those that enrolled or switched QHPs in 2016.

[23]The Commonwealth Fund, *Affordable Care Act Tracking Survey, February - April 2016* (July 2016), and PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, *Results From a Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace* (October 2015).

[24]Urban Institute, *Health Reform Monitoring Survey, Health Care Access and Affordability among Low- and Moderate-Income Insured and Uninsured Adults under the Affordable Care Act,* (Washington, D.C. April 21 2016). Data reflect the experiences of QHP enrollees with incomes less than 400 percent of the federal poverty level, or $47,080 for an individual or $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015.

[c]Kaiser Family Foundation, Survey of Non-Group Health Insurance Enrollees, Wave3 (Menlo Park, CA: May 20, 2016).

[d]PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, Results From a Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace (October 2015).

[e]Urban Institute Health Reform Monitoring Survey, Health Care Access and Affordability among Low- and Moderate-Income Insured and Uninsured Adults under the Affordable Care Act, (Washington, D.C. April 21, 2016). Data reflect the experiences of QHP enrollees with incomes less than 400 percent of the federal poverty level.

[f]We report the percent dissatisfied because the survey did not publish results for the percent of enrollees satisfied, and respondents also had the option to report that they were "neither satisfied or dissatisfied."

In addition to reporting satisfaction with their choice of providers, most QHP enrollees surveyed had used their health insurance coverage in 2015 or 2016, according to four national surveys that reported this information. For example, one national survey reported that about two-thirds of QHP enrollees reported using their plans to access care or purchase medication.[25] Three national surveys found that over half of QHP enrollees reported having a regular or routine check-up.[26] Another national survey reported that 62 percent of QHP enrollees who needed to see a specialist could do so within 2 weeks or less.[27]

[25]Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.* Another national survey reported that 73 percent of QHP enrollees with incomes less than 400 percent of the federal poverty level had a usual source of care and a low percentage, about 8 percent, had trouble finding a doctor as a new patient. See Urban Institute, *Health Reform Monitoring Survey.* Data reflect the experiences of QHP enrollees with incomes less than 400 percent of the federal poverty level, or $47,080 for an individual or $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015. A third national survey reported that most enrollees with ongoing medical problems reported getting most or all of the care they needed. See PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, *Survey of Individuals.*

[26]Specifically, one national survey reported that 58 percent of QHP enrollees visited a doctor for a well visit or routine checkup in the last 12 months. See Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers*. Another national survey reported that 53 percent of QHP enrollees had a check-up since signing up for QHP coverage. See PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, *Survey of Individuals*. A third national survey reported that 68 percent of QHP enrollees who were insured for the past year and had incomes below 400 percent of the federal poverty level reported having a routine check-up in the past year. See Urban Institute, *Health Reform Monitoring Survey.*

[27]The Commonwealth Fund, *Affordable Care Act Tracking Survey, February – April 2016* (May 2016).

Plan Affordability

Satisfaction with plan affordability among QHP enrollees who obtained their coverage through the exchanges was lower than for satisfaction with plans overall and for coverage and access. Nevertheless, about half or more of QHP enrollees surveyed reported satisfaction with their plan's affordability, according to the five national surveys that we reviewed. For example, two national surveys reported that about half or more of QHP enrollees found it easy to afford their plan's premium costs.[28] One national survey found that 45 percent of QHP enrollees reported high levels of confidence in their ability to obtain affordable care.[29] Another national survey reported rates of dissatisfaction, with 25 percent of QHP enrollees reporting being very or somewhat dissatisfied with the premiums they paid for their plans.[30] Finally, one national survey reported that approximately 60 percent of QHP enrollees were satisfied with various plan costs in 2016, such as annual deductibles and copayment amounts.[31] (See table 3).

[28]The Commonwealth Fund, *Affordable Care Act Tracking Survey*, *February – April 2016* (July 2016); and PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, *Survey of Individuals*.

[29]Deloitte Center for Health Solutions, *2016 Survey of US Health Care Consumers.*

[30]Data reflect the experiences of QHP enrollees with incomes less than 400 percent of the federal poverty level, or $47,080 for an individual or $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015. We report the percent dissatisfied because the survey did not publish results for the percent of enrollees satisfied, and respondents had the option to report that they were "neither satisfied or dissatisfied." See Urban Institute, *Health Reform Monitoring Survey.*

[31]Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, 2016.*

Table 3: Examples of National Survey Data on Qualified Health Plan (QHP) Enrollee Satisfaction with Plan Affordability, 2015 or 2016, among those Obtaining Coverage through the Exchanges

National Survey	Survey year	Percent of QHP enrollees reporting
Commonwealth Fund[a]	2016	• Confidence in ability to afford care if they became seriously ill: 61 percent • Ease in affording premiums: 49 percent[b]
Kaiser Family Foundation[c]	2016	• Satisfaction with monthly premium amount: 59 percent • Satisfaction with annual deductible amount: 51 percent • Satisfaction with doctor visit copayment amount: 67 percent • Satisfaction with prescription drug copayment amount: 64 percent
PerryUndem[d]	2015	• Ease in paying premiums: 56 percent
Deloitte[e]	2016	• High levels of confidence in their ability to get affordable care: 45 percent[f]
Urban Institute[g]	2015	• Dissatisfaction with premium amounts: 25 percent[h] • Dissatisfaction with protection that coverage provides against high medical bills: 25 percent[h]

Source: GAO. I GAO-16-761

Notes: The table presents the most recently available data as of July 2016. The surveys cannot be compared directly because, for example, each was conducted during different time periods and asked questions and recorded responses slightly differently. Although the surveys had relatively low response rates, all report that their results are nationally generalizable.

[a]The Commonwealth Fund, Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February – April 2016 (New York: July 7, 2016). Data reflect very or somewhat confident and very or somewhat easy, respectively.

[b]Data reflect adult QHP enrollees who pay all or some of their premium and were aware of their premium amount.

[c]Kaiser Family Foundation, Survey of Non-Group Health Insurance Enrollees, Wave3 (Menlo Park, Ca.: May 20, 2016). Data reflect very or somewhat satisfied.

[d]PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, Results From a Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace (October 2015). Data reflect very or somewhat easy to pay premiums.

[e]Deloitte Center for Health Solutions, 2016 Survey of US Health Care Consumers: A Look at Exchange Consumers (Washington, D.C.: May 2016).

[f]We refer to high levels of confidence because data are limited to survey responses of 8, 9 or 10, on a 10-point scale, where 1 is the lowest rating and 10 is the highest rating.

[g]Urban Institute Health Reform Monitoring Survey, Health Care Access and Affordability among Low- and Moderate-Income Insured and Uninsured Adults under the Affordable Care Act, (Washington, D.C.: April 21, 2016). Data reflect the experiences of QHP enrollees with incomes less than 400 percent of the federal poverty level, or $47,080 for an individual or $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015.

[h]We report the percent dissatisfied because the survey did not publish the results for the percent of enrollees satisfied, and respondents had the option to report that they were "neither satisfied or dissatisfied."

In addition to these five national surveys, other studies from our literature review reported similar data regarding QHP enrollees' satisfaction with plan affordability. Specifically, one narrowly focused study reported that 87 percent of QHP enrollees surveyed found their coverage to be affordable on the basis of their monthly budget.[32] Another study reported that many community stakeholders interviewed—including assisters, provider representatives, and department of insurance officials—stated that QHP enrollees could obtain care more easily and affordably than they could prior to the advent of the exchanges.[33]

Despite general satisfaction with plan affordability, one national survey of enrollees reported in 2016 that their satisfaction with certain plan costs had declined since 2014.[34] Another national survey reported that price was a common reason why enrollees were dissatisfied with their QHP in 2015.[35] Enrollee dissatisfaction with premium amounts prompts some to drop their coverage, according to experts and assisters we interviewed. Three of the national surveys we reviewed also reported that dissatisfaction with plan costs is a primary reason why QHP enrollees

[32]Center for American Progress, *Moving the Needle: The Impact of the Affordable Care Act on LGBT Communities.* (Washington, D.C.: Nov. 17, 2014). This study reported results from a nationally representative survey conducted in July 2014 of adults with incomes less than 400 percent of the federal poverty level, or $47,080 for an individual or $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015.

[33]Center on Health Insurance Reforms, Georgetown University Health Policy Institute, and the Robert Wood Johnson Foundation, *A Tale of Three Cities: How the Affordable Care Act is Changing the Consumer Coverage Experience in 3 Diverse Communities*, (Washington, D.C.: April 2016).

[34]See Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, 2016.*

[35]Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.*

switch plans.[36] HHS recently reported that those who switched plans for 2016 generally moved to lower-cost plans.[37]

Concerns Have Been Noted by Stakeholders and in Research about Some Enrollees' Ability to Afford and Access Care

Although available data show most QHP enrollees were satisfied overall with their plans, our interviews with stakeholders—including experts, assisters, state department of insurance and exchange officials—and our review of literature, also revealed concerns about some QHP enrollees' ability to afford and access their care, and understand their QHP, among other things.

Affording Care

Some enrollees have concerns about affording care before reaching their deductible, according to experts we interviewed and our review of literature. Specifically, some individuals have reported concerns affording care, or have been deterred from seeking care, because they found it too expensive to pay for their out-of-pocket expenses before reaching their deductibles, according to experts we interviewed.[38] Two national surveys of QHP enrollees found that over a quarter of them had experienced financial difficulties paying for their out-of-pocket health care expenses in the prior year, with some enrollees reporting unmet health care needs

[36]Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers*; PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, *Survey of Individuals;* and Vermont Health Connect, *Customer Satisfaction Spring 2015 Survey.*

[37]Specifically, HHS found that QHP enrollees who switched plans for 2016 saved an average of $42 per month, compared to what they would have paid if they had not switched plans. HHS Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015–2016* (Washington, D.C.: April 12, 2016).

[38]Beginning in 2017, issuers in the FFE will have the option to offer standardized plan options to consumers. CMS is encouraging issuers to offer at least one standardized QHP option in 2017 to enable consumers to more easily compare QHPs offered by different issuers. Among other things, standardized plans will have the same deductible, cost-sharing limits, and copayments or coinsurance for a key set of essential health benefits provided by in-network providers and will exempt certain routine services from the deductible, such as primary care visits and generic drug costs. 81 Fed. Reg. 12204, 12289 (Mar. 8, 2016).

due to cost.[39] One national survey reported that in 2016, 25 percent of QHP enrollees reported higher-than-expected out-of-pocket costs after using their coverage.[40]

Cost is a driving factor in QHP enrollees' selection of a plan. According to three national surveys of QHP enrollees, premiums, deductibles, and copayments were the top factors that consumers used when selecting a QHP in 2015.[41] In addition, an HHS analysis of QHP selection in the FFE reported that enrollees tended to select QHPs with the lowest premiums among those offering similar levels of coverage.[42] Indeed, high-deductible health plans remain popular options among QHP enrollees, potentially because these plans tend to have lower premiums.[43] One national survey reported that in 2016, 46 percent of QHP enrollees chose a plan with a

[39]Specifically, one survey found that, in 2015, 34 percent of continuously enrolled QHP enrollees had problems paying for out-of-pocket expenses, and 16 percent of continuously enrolled QHP enrollees had not sought treatment when sick or injured due to cost concerns. See Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.* Another 2015 survey found that 26 percent of QHP enrollees who were insured for the past year and had incomes below 400 percent of the federal poverty level reported problems paying family medical bills over the last year, and because of cost concerns, 18 percent of such QHP enrollees reported unmet prescription drug needs and 15 percent of such QHP enrollees reported unmet needs for specialist care in the past year. See Urban Institute *Health Reform Monitoring Survey*.

[40]Deloitte Center for Health Solutions, *2016 Survey of US Health Care Consumers.*

[41]The Commonwealth Fund, *To Enroll or Not To Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (New York: Sept. 25, 2015); Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, 2015;* and Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.*

[42]HHS Assistant Secretary for Planning and Evaluation, *Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014,* (Washington, D.C.: June 18, 2014).

[43]One national survey reported that lower-income individuals enrolled in high-deductible QHPs were the least confident in their ability to afford care if they became seriously ill. Specifically, 54 percent of those with incomes under 250 percent of the federal poverty level enrolled in QHPs with deductibles of $1,000 or more were confident in their ability to afford care, compared with 78 percent of enrollees with the same income level whose QHPs had lower deductibles. The Commonwealth Fund, *Affordable Care Act Tracking Survey, March-May 2015* (September 2015).

high deductible.[44] While many consumers believe at the time of their enrollment that their QHP will be affordable, some enrollees become overwhelmed after seeking care when trying to balance the need to pay out-of-pocket costs in addition to monthly premiums and other life expenses, according to experts we interviewed. Two factors that may contribute to QHP enrollees' dissatisfaction with plan affordability is that many QHP enrollees have lower incomes and have been previously uninsured; as such, these individuals may not have previously had to pay for their health care expenses or balance the need to pay for them along with other life expenses.[45]

While some QHP enrollees perceive their premium and cost-sharing amounts to be unaffordable, most have received federal subsidies that were designed to help make their coverage more affordable. Specifically, CMS reported that 84 percent of QHP enrollees were receiving advance payments of the premium tax credit, and 56 percent of QHP enrollees were receiving cost-sharing reduction assistance to help offset their out-of-pocket expenses, as of December 2015.[46] According to one national survey, about 60 percent of QHP enrollees paid either nothing or less than $125 per month in premiums in 2015 and 2016—amounts reported as comparable to those for employer-sponsored coverage.[47]

Accessing Care

Some QHP enrollees who obtained their coverage through the exchanges have faced problems accessing care after enrollment due to both midyear

[44]This survey defined a high deductible health plan as one that had a deductible of $1,500 for individual coverage or $3,000 for family coverage. See Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, 2016.*

[45]According to Kaiser Family Foundation's 2014 nationally representative survey, 57 percent of QHP enrollees were uninsured immediately prior to enrolling in their QHP. Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, 2014* (June 2014). According to CMS data, at least 84 percent of QHP enrollees as of December 2015 had incomes between 100 and 400 percent of the federal poverty level—$11,770 to $47,080 for an individual or $24,250 to $97,000 for a family of four in the contiguous United States or the District of Columbia in 2015.

[46]The average advance premium tax credit that QHP enrollees received was $272 per month, as of December 2015.

[47]The Commonwealth Fund, *Affordable Care Act Tracking Survey, March-May 2015* (Sept. 2015) and The Commonwealth Fund, *Affordable Care Act Tracking Survey*, *February – April 2016* (July 2016).

changes in QHP provider networks and the unavailability of accurate information about provider networks and formularies at the time of enrollment, according to experts we interviewed and our review of literature.[48] For example, one report noted widespread confusion among consumers and providers about which providers were included in a plan's network.[49] In addition, a 2015 survey of assisters found that half of the assisters had encountered enrollees who sought help because their provider was not in-network.[50] A report examining state regulation of QHPs found that in 2014, only a minority of states enforced rules about frequency in updating provider directories.[51] Two recent studies of the accuracy of provider directories for QHPs offered in Maryland and Washington, D.C. found that about half of the psychiatrists listed in the provider directories could no longer be reached at the phone numbers

[48]Problems with provider network directory accuracy and midyear network changes are not unique to QHPs but rather are long-standing concerns of the private health insurance market, according to literature we reviewed. CMS recently adopted new requirements that address midyear changes in QHP provider networks. As of 2017, QHP issuers in all FFEs must notify enrollees about a discontinuation of an in-network provider at least 30 days prior to the effective date of the change or otherwise as soon as practicable and, in certain cases, allow ongoing treatment to continue for up to 90 days at in-network cost-sharing rates in cases where a provider is terminated without cause. 81 Fed. Reg. 12204, 12349-12350 (Mar. 8, 2016) (to be codified at 45 C.F.R. § 156.230(d)). Some states have also taken action to protect consumers from midyear changes in provider networks and inaccurate provider directories. For example, in 2015, California enacted legislation that requires issuers to update their online directories at least weekly, creates a process for the public and providers to report possible inaccuracies, and requires issuers to guarantee coverage at in-network rates if an enrollee reasonably relied on inaccurate or misleading information in the plan's provider directory, among other things. 2015 Cal. Adv. Legis. Serv. 649 (LexisNexis).

[49]Center on Health Insurance Reforms, Georgetown University Health Policy Institute, *Implementation of the Affordable Care Act: Cross-Cutting Issues Six-state Case Study on Network Adequacy.* (Washington, D.C.: September 2014).

[50]Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Menlo Park, Ca: August 2015).

[51]The Commonwealth Fund, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks* (New York: May 5, 2015).

directories listed.[52] Officials from CMS and state departments of insurance, as well as other stakeholders, also told us that enrollees have faced challenges verifying their coverage or otherwise communicating with the issuer before receiving their insurance cards, which can result in treatment delays.

Concerns have been expressed both by some experts and in literature we reviewed about QHP enrollees' ability to obtain or continue care given the increased prevalence of QHPs with narrow networks. Issuers have increasingly begun to offer narrow network plans as a mechanism to lower premiums; these plans offer coverage for services through a smaller group of physicians or hospitals than the plan has covered in the past.[53] For example, a narrow network plan may only offer in-network coverage through one local hospital. One analysis reported that QHPs offered on the exchanges included 34 percent fewer providers, on average, than plans offered outside the exchanges.[54] Another report identified 16 states where at least half of all QHPs offered had narrow networks.[55] While stakeholders have expressed concerns with these

[52]Specifically, 57 percent of all psychiatrists listed in 2014 Maryland QHP provider directories were no longer working at the number listed. Mental Health Association of Maryland, *Access to Psychiatrists in 2014 Qualified Health Plans: A Study of Network Accuracy and Adequacy Performed from June 2014-November 2014* (Lutherville, Md: Jan. 26, 2015). Separately, in a study of 150 randomly selected psychiatrists listed in provider directories for the top three carriers offering QHPs in Washington, D.C., 49 percent were found to be no longer working at the number listed. American Psychiatric Association, *Availability of Health Insurance Exchange Network Psychiatrists for the Largest Insurance Carriers in Washington, D.C.* (Arlington, Va.: May 16, 2016).

[53]Narrow networks have been introduced to plans sold both on and off the exchanges. Center on Health Insurance Reforms, Georgetown University Health Policy Institute, and Urban Institute, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care* (Washington, D.C.: May 2014).

One recent analysis found that premiums for QHPs sold in the most commonly purchased (silver) tier that had broad networks were, on average, 22 percent higher for plans as compared with those with narrow networks in 2016. See McKinsey Center for U.S. Health System Reform, *Hospital networks: Perspective from three years of exchanges* (March 5, 2016).

[54]Avalere Health, *Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans* (Washington, D.C.: July 15, 2015).

[55]Polsky D., and Weiner, J., *State Variation in Narrow Networks on the ACA Marketplaces.* (Philadelphia, Pa.: August 2015).

plans, consumers continue to enroll in them and indicate they are willing to choose a plan with a narrow network to reduce their premiums. For example, one national survey of QHP enrollees reported that over forty percent of those with the option for a narrow network plan in 2016 enrolled in such a plan.[56] Another national survey found that nearly 60 percent of QHP enrollees said in 2015 that they would be willing or somewhat willing to accept a smaller network of hospitals or doctors in exchange for lower overall health care payments.[57]

Understanding QHPs

Some QHP enrollees who obtained their coverage through the exchanges have faced difficulties understanding how to use their plans, according to our interviews with stakeholders and our review of literature.[58] Specifically, about half of nationwide QHP enrollees surveyed in 2015 had a good understanding of their plan benefits and total health coverage costs at the time of enrollment, according to one national survey.[59] One factor that may contribute to enrollees' difficulty in understanding their plans is that because many of those who have obtained coverage through the exchanges were previously uninsured, they may be unaccustomed to health insurance terminology—words such as premiums, coinsurance, deductibles, and out-of-pocket maximums—as well as health insurance practices such as navigating plan networks and formularies.[60] For example, a 2015 survey of assisters reported that about three-quarters of assisters noted that most or nearly all consumers who shopped for or

[56]The Commonwealth Fund, *Affordable Care Act Tracking Survey*, *February – April 2016* (July 2016).

[57]Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.*

[58]Problems with health literacy are not unique to QHP enrollees but rather are a long-standing concern of the private health insurance market, according to literature we reviewed.

[59]Specifically, at the time of enrollment, 51 percent of QHP enrollees surveyed in 2015 reported having a good understanding of plan benefits and 55 percent reported having a good understanding of total health coverage costs. Deloitte Center for Health Solutions, *2015 Survey of US Health Care Consumers.*

[60]In 2014, CMS launched its *From Coverage to Care* initiative that provides resources to help inform and educate consumers about health insurance concepts. For additional information on this initiative, see https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Coverage2Care.html; website last accessed July 14, 2016. Some navigators we interviewed told us that they routinely used the *From Coverage to Care* resources and found them to be helpful.

enrolled in a QHP needed help understanding basic health insurance concepts such as deductibles and in-network services.[61] Another study reported that assisters spent considerable time helping QHP enrollees understand how to use their plan, including by explaining key insurance terms, provider networks, the financial risks of using out-of-network care, and the use of appropriate care settings.[62] For example, some QHP enrollees who were previously uninsured did not realize that they should no longer use a hospital emergency room as their primary care location.

In addition to facing difficulties understanding general health insurance concepts, some QHP enrollees have found it challenging to understand exchange-specific terminology, according to our review of the literature. For example, a 2015 survey of Vermont QHP enrollees found that less than one-third of enrollees fully understood exchange-specific terms, such as advanced premium tax credit and cost-sharing reduction.[63]

Furthermore, according to experts and assisters we interviewed, some enrollees also face language barriers, which can compound their difficulty in understanding how to use their QHP.[64] Some assisters we interviewed told us that some enrollees take time off from work in order to travel to their offices for help translating and understanding notices they receive from CMS and issuers.[65]

Other Concerns

To varying degrees, QHP enrollees who obtained their coverage through the exchanges have also faced a range of other challenges related to

[61]Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Menlo Park, Ca.: Aug. 6, 2015).

[62]Center on Health Insurance Reforms, Georgetown University Health Policy Institute, *Consumers' Coverage Experience (*April 2015).

[63]Vermont Health Connect, *Customer Satisfaction Spring 2015 Survey.*

[64]CMS requires exchanges and QHP issuers to make certain health insurance information, such as applications, notices pertaining to benefits and coverage, provider directories and formularies, available in non-English languages spoken in their state. See 45 CFR §§ 155.205(c), 156.250 (2015).

[65]Navigators are required to provide information that is culturally and linguistically appropriate to the needs of the population being served by the exchange, including individuals with limited English proficiency, and the exchanges are required to provide information to such enrollees through the provision of language services at no cost to the individual. 45 C.F.R. §§ 155.205(c)(2), 155.210(e)(5) (2015).

their health insurance plans, according to assisters and state department of insurance and exchange officials we interviewed and literature we reviewed. For example, some assisters told us about difficulties that enrollees have faced in updating information with CMS, including modifying income information and adding family members to plans.[66] An assister also told us that enrollees have faced difficulties obtaining information from CMS during the appeals process—for example, information about the status of appeals in progress, or the rationale for appeal decisions.[67] In addition, officials from state departments of insurance, exchange offices, and assisters told us about other state-specific challenges that enrollees have faced. According to Vermont exchange officials and assisters we interviewed, QHP enrollees in that state had faced some challenges related to billing. For example, enrollees had received incorrect premium statements, bills for premiums that were already paid but not recognized by the system, or incorrect medical bills for services received, according to assisters in that state.[68] In another example, state department of insurance officials and assisters in Montana told us that some individuals in that state had become dually enrolled in Medicaid and a QHP after the state expanded eligibility for its Medicaid program in 2016.[69] This dual enrollment is problematic as individuals may be held liable for repaying certain exchange subsidies received during the period of duplicate coverage. Further, the federal government could be

[66]Exchange enrollees are required to update any changes in circumstances affecting their eligibility for coverage or financial assistance within 30 days of the change. 45 C.F.R. § 155.330(b) (2015). Exchanges are also required to allow individuals who have a qualifying life event, such as losing minimum essential coverage, having a baby or getting married, to qualify for a special enrollment period to either obtain a health plan or to change their health plan, as well as qualify for financial assistance. 45 C.F.R. § 155.420(d) (2015).

[67]The exchanges are required to establish an appeals process to allow exchange applicants or enrollees to appeal exchange eligibility determinations for coverage including accessing coverage outside of open enrollment (i.e., special enrollment periods) and eligibility for financial assistance such as the amount of advanced payments of the premium tax credit, as well as other issues. 45 C.F.R. § 155.505. (2015).

[68]Vermont exchange officials told us that they had resolved these billing issues.

[69]Medicaid is the joint federal-state health coverage program for certain low-income individuals. PPACA authorizes states to expand eligibility for Medicaid; states that opt to expand Medicaid may cover most non-elderly adults whose income is at or below 138 percent of the federal poverty level.

Montana state department of insurance officials we interviewed told us that they were working with CMS to address this dual-enrollment problem.

paying twice, subsidizing exchange coverage and reimbursing states for Medicaid spending for those enrolled in both.[70]

CMS and Selected States Have Monitored Post-Enrollment Experiences by Reviewing Information Reported by Consumers and Assisters

CMS and the five selected states in our review have monitored QHP enrollees' post-enrollment experiences by reviewing information reported by consumers, through call centers and enrollee surveys, as well as by assisters. CMS and selected states use this information to ensure that enrollee issues are resolved and to improve educational resources and post-enrollment assistance for enrollees, among other purposes. In addition to monitoring QHP enrollee experiences through these methods, CMS and the selected states conduct activities to monitor QHPs. (See App. II).

Consumer Call Centers

CMS uses information collected from enrollees through its call center to monitor QHP post-enrollment experiences. QHP enrollees and their representatives, such as assisters, may call the CMS exchange call center to request agency assistance in resolving concerns.[71] Using its casework system, CMS tracks individual issues—referred to as cases—that require action on the part of an issuer, state, or CMS to resolve.[72] In 2014 and 2015, agency officials assigned all cases to one of four broad

[70]We previously reported on weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage in Medicaid and QHPs in FFE states. See GAO, *Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential Gaps and Duplications in Coverage*, GAO-16-73 (Washington, D.C.: Oct. 9, 2015).

[71]CMS officials told us that the agency works collaboratively with consumers and issuers to resolve reported concerns. According to CMS, 99 percent of calls to the marketplace call center relate to QHPs offered through the FFE, and they forward any information related to SBEs back to the states.

[72]According to CMS officials, cases may include requests, such as requests for address changes, requests to terminate coverage, and requests to obtain another copy of a form; general reports of concern, for example, regarding issuer compliance; individual complaints such as those related to denials of coverage; and complex questions, including those related to tax forms. CMS procedures state that the agency generally only considers matters that require an action on the part of an issuer to be cases after the individual has first sought resolution with their issuer or state department of insurance.

categories of concerns—plan and issuer, tax filing, eligibility, or legal and administrative—as well as to subcategories within each category that describe the general nature of the issue.[73] Cases related to post-enrollment issues may be included in any of these categories.

To identify trends in cases and to ensure their timely resolution, CMS officials prepare and examine weekly and monthly reports that include information on the type and volume of cases received and resolved by category, among other information. According to our analysis of CMS exchange casework data, three-quarters of CMS's casework in 2014 and 2015 was in the plan and issuer category, which includes post-enrollment concerns such as enrollee access to services or benefits, among other issues. (See table 4.) Appendix III includes more detailed information about CMS QHP casework in 2015.

Table 4: Summary of Centers for Medicare & Medicaid Services (CMS) Exchange Casework, 2014-2015

Category	Number of cases	Percentage
Plan and issuer[a]	1,412,153	75.4
Tax filing[b]	332,596	17.8
Eligibility[c]	127,951	6.8
Legal and administrative[d]	378	0
Total	**1,873,078**	**100**

Source: GAO analysis of CMS data as of February 2016. I GAO-16-761

[a]Plan and issuer cases include issues such as enrollment and disenrollment requests, premium payment problems, and problems with access to services.

[b]Tax filing cases include issues such as requests for an additional copy of tax forms and requests for CMS review of information included on tax forms.

[c]Eligibility cases include issues such as problems with identity verification or completing an application.

[d]Legal and administrative cases include issues such as program integrity allegations and areas of potential non-compliance with state or federal rules.

[73]The plan and issuer category includes cases that an issuer has the responsibility to resolve, such as enrollment and disenrollment requests. The tax filing category includes requests for an extra tax form and requests for CMS to review tax form information. The eligibility category includes issues with completing an enrollment application. The legal and administrative category includes cases related to program integrity allegations or potential non-compliance with state or federal rules.

CMS shares relevant casework information with the appropriate agency, issuer, or state officials for research and timely resolution, depending on the type of action required, according to CMS officials we interviewed.[74] For instance, CMS officials told us that cases noting concerns about issuer compliance are forwarded to CMS's compliance team for further investigation.[75] CMS officials told us that they work with individual issuers to ensure that cases are resolved in a timely manner and the causes of any casework trends are addressed. For example, CMS has a monthly call with issuers to discuss casework trends and strategies to improve consumer experiences, in addition to providing ongoing technical assistance with specific casework issues, according to CMS officials.

In addition to reviewing casework to resolve individual enrollee concerns, CMS officials we interviewed reported reviewing casework data relevant to their oversight responsibilities of issuers. For example, prior to conducting any issuer compliance reviews, CMS officials told us that they review relevant casework data, such as complaints, for the issuer. In addition, CMS officials told us that, as of 2016, they have begun using casework information to identify issuers for compliance review, including by reviewing any outliers in volume or timely resolution of cases.

The five selected states included in our review have also used information submitted directly by enrollees through state call centers or online complaint systems to monitor enrollee experiences in both FFE and SBE states. Officials from all five of the selected states' departments of insurance we interviewed reported tracking consumer complaints at the issuer level and working to resolve reported issues. Four of the selected

[74]CMS requires issuers of QHPs in the FFE to resolve urgent cases—those related to an immediate need for health services—within 72 hours of receipt, and all other cases within 15 days of receipt, or sooner if required by applicable state law. 45 C.F.R. §156.1010(d) (2015). CMS officials told us that because the majority of cases that CMS must resolve are not urgent, the agency aspires to resolve all cases within 15 days; however, complicated cases requiring research may take longer.

[75]Agency officials told us that they had not received any significant concerns about potential issuer non-compliance. An example of a significant concern would be a complaint that a particular issuer had consistently denied high cost services. If such a complaint were received, CMS officials told us that they would forward the issue to their compliance team to determine whether the issuer had engaged in practices that would have the effect of discouraging the enrollment of individuals with significant health needs. See 45 C.F.R. § 156.225 (2015).

states' departments of insurance did not have any mechanism to track QHP-related complaints separate from those of other plans, according to state department of insurance officials we interviewed. One state—Indiana—began tracking QHP-related complaints in 2016 in categories such as billing, claim delay, and pharmacy benefits. In addition to monitoring complaints reported directly to them, state department of insurance officials located in FFE states have access to CMS's casework system for all issuers operating in their state. Officials from departments of insurance in two of the three FFE states included in our review told us that they routinely monitored casework data in CMS's system.[76]

QHP Enrollee Surveys

CMS and the two states operating SBEs included in our review have surveyed or plan to survey QHP enrollees to monitor their experiences. Specifically, CMS developed a survey, which was administered to a sample of QHP enrollees nationwide, including those in FFE and SBE states, about their experiences with their plans in 2015 and 2016.[77] CMS designed the survey to capture accurate and reliable information from consumers about their experiences with the health care and services they had received through their QHP and to allow for effective oversight, among other purposes. The survey, which was beta-tested in 2015, was

[76]State department of insurance officials in one state—Montana—reported that they had not routinely accessed CMS's casework system. According to Montana department of insurance officials, CMS requires users to provide personal information, including their social security number, in order to gain access to the system, and the department of insurance decided not to require their employees to provide such information in order to monitor CMS casework information. However, a state department of insurance official noted that, as of August 2016, they are collaborating with CMS to resolve certain consumer complaints, and they are in the process of training staff to use CMS's system.

[77]PPACA required CMS to establish an enrollee satisfaction survey system. 42 U.S.C. § 18031(c)(4). CMS developed the QHP Enrollee Experience Survey, and QHP issuers contracted with vendors to administer it.

administered to enrollees of QHPs with more than 500 enrollees.[78] It included a core set of questions for enrollees on key areas of care and service, including overall rating of their QHP, the availability of information about their health plan and costs of care, how well they were able to get needed care, and the accessibility of information in a needed language or format. CMS officials told us that they ultimately expect the results of their 2017 and future surveys to, among other things, inform the agency's monitoring of enrollee post-enrollment experiences, as well as their monitoring of issuers beginning in 2017. For example, CMS officials told us that they expect to use survey results to identify issues in enrollee overall satisfaction and access to care. CMS officials told us that they had also shared relevant 2015 survey results, and plan to share 2016 results, with issuers and SBEs to help inform their understanding of enrollee experiences.

SBEs in two of the five selected states in our review had either already surveyed statewide QHP enrollees about their post-enrollment experiences or had plans to do so. Specifically, as mentioned earlier in this report, Vermont QHP enrollees were surveyed in 2015 to assess their satisfaction with their QHP. Officials from the state's exchange office told us that they used the survey results to inform their prioritization of work related to improving enrollee experiences, such as developing better methods to educate enrollees on financial literacy and health insurance information, and to work with issuers to ensure that consumers with complaints are using the appropriate channels for filing them. While they have no plans to repeat the survey, officials from the state's exchange office told us that they plan to add questions to another statewide survey that is conducted every two years or develop a shorter survey as an attempt to monitor QHP enrollee experiences over time. Officials from Colorado's exchange office told us in July 2016 that they were in the

[78]CMS's 2015 survey captured information from 64,161 QHP enrollees, and as of June 27, 2016, CMS was in the process of reviewing the response rate for the 2016 survey. The purpose of the 2015 beta test was to refine the survey processes and share preliminary results with issuers. CMS does not plan to make the results of the 2015 or 2016 surveys publicly available for all exchanges; however, agency officials told us that they plan to make the results of future versions of the survey publicly available for all exchanges. CMS expects to provide comparable information to consumers about the quality of health care services and enrollee experiences with QHPs in a quality rating system, which will incorporate some results from its QHP enrollee survey. A few selected states will display selected results from the 2016 survey during the 2017 open enrollment period as part of a pilot of the display of the quality rating system.

process of surveying statewide QHP enrollees in 2016 about their experiences with their plans, including those related to post-enrollment.

Assisters

CMS and states have also monitored enrollee experiences with information received from assisters. CMS receives some post-enrollment information from navigators and other assisters on an ongoing basis as it relates to enrollees in FFE states. For example, federally funded navigators are required to report the number of post-enrollment meetings they have held with QHP enrollees on a weekly basis, and, according to CMS, the agency plans to require such navigators to report more detailed information related to their post-enrollment work with enrollees.[79] In addition, post-enrollment issues are occasionally discussed during weekly meetings that CMS officials hold with navigators to discuss their ongoing work, according to CMS officials and navigators we interviewed. While the requirement to report post-enrollment information to CMS is only applicable to federally funded navigators, agency officials told us that they occasionally receive some post-enrollment information from other assisters, or from consumer advocacy groups who work with them, on an informal basis. For example, CMS officials reported receiving some information from assisters about low levels of health literacy among QHP enrollees.

CMS officials told us that they use information they receive from navigators and other assisters to help them troubleshoot FFE enrollee problems, clarify policy, and develop additional training or materials for dissemination. Specifically, CMS circulates weekly newsletters to federally funded navigator grantees that address current areas of interest among navigators. Recent topics in these newsletters have included conducting culturally competent outreach and the appeals process. One navigator we interviewed told us they found these newsletters helpful because they explained relevant issues and presented solutions. CMS officials told us that they have also developed webinars to address post-enrollment issues identified by assisters; recent webinars addressed

[79]Specifically, CMS plans to collect additional post-enrollment information from federally funded navigators, including the number of consumers who sought assistance related to health literacy, locating providers, billing issues, tax forms, and other post-enrollment topics. CMS officials told us that they intend to use this information to enhance their understanding of the types of assistance consumers are seeking from navigators, as well as their knowledge of enrollees' post-enrollment experiences.

topics such as helping consumers after the open enrollment period, transitioning from a QHP to other coverage, and assisting consumers during the tax-filing seasons.

The five selected states in our review, including those using the FFE and operating an SBE, have also gathered some information about enrollees' post-enrollment experience from assisters, including navigators, operating in their state, according to state department of insurance officials and assisters we interviewed. The amount of information that assisters shared with these selected state officials varied and tended to be informal, as the selected states' departments of insurance do not require navigators and assisters operating in their state to report any information about consumers' post-enrollment experiences, according to officials and assisters we interviewed.

Exchange offices in the two selected states in our study that operated an SBE, Colorado and Vermont, required their state-funded assisters to routinely report information about the post-enrollment assistance they provided, according to officials and assisters, and, officials from the state exchange offices told us that they use this information to, among other things, identify and address any problems related to enrollees' experiences with their QHPs, or identify training needs.

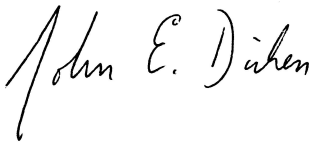
To the extent that assisters report information about consumers' post-enrollment experiences to state officials in either FFE or SBE states, the information they provide tends to be about individual issues as they work with consumers to address them, according to the assisters and officials from state departments of insurance and exchange offices we interviewed. However, we found that assisters operating in four of the five selected states included in our review have also shared information about trends in QHP enrollee post-enrollment experiences to state department of insurance and exchange officials. For example, according to an official at the Montana department of insurance, assisters informed state officials about QHP enrollees who were found to be dually enrolled in Medicaid and have worked with state department of insurance and CMS officials to address the issue. Similarly, assisters operating in North Carolina and Colorado also told us that they have shared information with their department of insurance and exchange office, respectively, about trends in consumers' experiences, including those related to post-enrollment that the issuer has the responsibility to resolve.

Agency Comments

We provided a draft of this report to HHS for comment; HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in Appendix IV.



John Dicken
Director, Health Care

List of Committees

The Honorable Orrin Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable John Kline
Chairman
The Honorable Robert C. Scott
Ranking Member
Committee on Education and the Workforce
House of Representatives

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Methodology Information for Literature Review and Five National Surveys

To examine what is known about the early experiences of enrollees in qualified health plans (QHP) obtained through the exchanges, we conducted a structured search of research databases using various combinations of relevant search terms including, “Affordable Care Act,” “qualified health plan,” “marketplace,” and “exchange,” to identify any literature published from January 1, 2014, through April 30, 2016, that reported on QHPs obtained through the exchanges.[1] We then reviewed the abstracts for 643 articles and the full text of 275 of those articles to determine whether they included information about QHP enrollees’ post-enrollment experiences and otherwise met our inclusion criteria. Our inclusion criteria included journal articles and government publications, as well as policy briefs or papers. Based on these steps, we identified 5 nationally representative surveys whose results were published in 14 articles between June 19, 2014, and July 7, 2016, and then summarized the QHP enrollee experiences on which these articles reported.[2]

To assess the reliability of the data presented in these surveys, we interviewed or corresponded with the authors of all of the survey reports, reviewed supporting documentation to understand what the surveys measured, and we examined the data for apparent errors. Although the surveys had relatively low response rates, they each reported that their results are nationally generalizable within certain margins of sampling error. In addition, the surveys reported similar results with respect to enrollee experiences. Based on these steps, we found the data to be sufficiently reliable for our purposes. The key methodological attributes of the five surveys are presented in table 5.

[1]We searched multiple bibliographic databases, including Biosis Previews, Embase, Medline, Nexis, PolicyFile, ProQuest Health and Medical Collection, and SciSearch, among others.

[2]We included subsequent versions of surveys identified through our review of literature published from January 1, 2014, through April 30, 2016.

Table 5: Key Methodological Information for Nationally Representative Surveys of Qualified Health Plan (QHP) Enrollees, among those Obtaining Coverage through the Exchanges

Survey name	Survey time period	Survey response rate (percent)[a]	Number of QHP enrollee respondents[b]	Margin of sampling error (percentage point)[c]
The Commonwealth Fund Affordable Care Act Tracking Survey	April – June 2014	14.0	414[d]	+/- 2.1[e]
	March – May 2015	12.8	459[d]	+/- 2.1[e]
	February – April 2016	13.9	432	+/- 2.0[e]
Deloitte Survey of US Health Care Consumers	January – February 2015	Not reported	406	+/- 4.9
	February – March 2016[d]		804	+/- 3.5[d]
Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees	April – May 2014	12.0[d]	340	+/- 6.0
	February – April 2015	13.0[d]	494	+/- 6.0
	February – March 2016	10.0[d]	512	+/- 5.0
PerryUndem Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace	August 2015	6.0[f]	1,012	+/-4.8
Urban Institute Health Reform Monitoring Survey	September 2015	4.8[d, f]	353[d, g]	+/-7.2[d, g]

Source: GAO. I GAO-16-761

Note: Despite relatively low response rates, each survey's documentation indicates that its results are nationally generalizable within the indicated margins of sampling error.

[a]Response rate refers to the overall survey sample; some surveys also gathered information from non-QHP enrollees.

[b]The number of QHP enrollee respondents refers to those who obtained coverage through the exchanges.

[c]Unless otherwise noted, sampling errors listed correspond to the sample of QHP enrollees obtaining coverage through the exchanges.

[d]Unpublished data provided by the survey's authors.

[e]Sampling error corresponds to the survey's entire sample, which includes over 4,000 individuals who do not have QHP coverage.

[f]Survey response rate is cumulative, reflecting those who met various screening criteria (for example, by having obtained a QHP through the exchanges or completing a demographic questionnaire) and completed the survey.

[g]Data correspond to exchange enrollee respondents with family incomes less than 400 percent of the federal poverty level.

The studies summarizing the survey results that were identified through our literature search are as follows, grouped by survey:

The Commonwealth Fund Affordable Care Act Tracking Survey

The Commonwealth Fund, Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction,

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February – April 2016 (New York: July 7, 2016).

The Commonwealth Fund, Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February – April 2016 (New York: May 25, 2016).

The Commonwealth Fund, Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015 (New York: Sept. 25, 2015).

The Commonwealth Fund, To Enroll or Not To Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not (New York: Sept. 25, 2015).

The Commonwealth Fund, Americans' Experiences with Marketplace and Medicaid Coverage, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015 (New York: June 12, 2015).

The Commonwealth Fund, Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces? (New York: Sept. 18, 2014).

The Commonwealth Fund, Gaining Ground: Americans' Health Insurance Coverage and Access to Care after the Affordable Care Act's First Open Enrollment Period, (New York: July 10, 2014).

Deloitte Center for Health Solutions Survey of US Health Care Consumers

Deloitte Center for Health Solutions, 2016 Survey of US Health Care Consumers: A Look at Exchange Consumers. (Washington, D.C.: May 11, 2016).

Deloitte Center for Health Solutions, Public Health Insurance Exchanges: Opening the Door for a New Generation of Engaged Health Care Consumers, 2015 Survey of US Health Care Consumers (Washington, D.C.: Aug. 3, 2015).

Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees

Kaiser Family Foundation, Survey of Non-Group Health Insurance Enrollees, Wave 3 (Menlo Park, CA: May 20, 2016).

Kaiser Family Foundation, Survey of Non-Group Health Insurance Enrollees, Wave 2 (Menlo Park, CA: May 21, 2015)

	Kaiser Family Foundation, Survey of Non-Group Health Insurance Enrollees (Menlo Park, CA: June 19, 2014).
PerryUndem Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace	PerryUndem Research/Communication, GMMB, and the Robert Wood Johnson Foundation, Results From a Survey of Individuals Who Purchased Health Plans Through the Health Insurance Marketplace (October 2015).
Urban Institute Health Reform Monitoring Survey	Urban Institute, Health Reform Monitoring Survey, Health Care Access and Affordability among Low- and Moderate-Income Insured and Uninsured Adults under the Affordable Care Act, (Washington, D.C.: April 21, 2016).

Appendix II: CMS and Selected States' Oversight of Qualified Health Plans

CMS and the selected states we reviewed conduct oversight of qualified health plans (QHP) offered on the exchanges to ensure that they comply with federal standards. This oversight generally includes certifying that QHPs have met these federal standards before consumers enroll in the QHP, although CMS also conducts a post-certification review as part of its oversight to ensure that certified QHPs are ready for enrollees to use in the plan year. To ensure that issuers are continuing to meet standards during the plan year, CMS and states also conduct compliance reviews and other ongoing monitoring activities. CMS and state oversight activities vary, depending on whether states utilized the federally facilitated exchange (FFE) or a state-based exchange (SBE). In 2016, 34 states utilized the FFE and 17 states operated an SBE.[1]

QHP Certification Reviews

In order for a QHP to be offered on the exchanges, CMS, the SBE, or state department of insurance officials must first certify that the QHP meets all relevant federal standards. Specifically, QHP issuers must be state licensed and meet a range of other standards in order for the plan to be offered on either the FFE or a SBE. For example, these other standards include serving a geographic area that is established without regard to racial, ethnic, language or health status factors and providing enrollees with access to a sufficient number and type of covered providers to assure all services will be accessible without unreasonable delay.[2]

For all QHPs offered on the FFE, CMS reviews plan information and is responsible for ensuring that the plan meets federal standards prior to the annual open enrollment period. Issuers submit an application with plan data to CMS for review, and CMS officials told us they review all applications for current and new issuers and send information to issuers with corrections prior to certification. Officials from two selected FFE states said that they conducted reviews for QHP certifications in parallel with CMS using the same federal exchange standards and submitted recommendations for QHP certification to CMS. CMS officials told us that they examine the information and recommendations submitted by states

[1]In our five selected states, Colorado and Vermont each administered an SBE, and Indiana, Montana, and North Carolina used the FFE, for the 2014 through 2016 plan years.

[2]See 45 CFR § 155.1000 (2015).

and may conduct additional reviews to investigate any concerns that state officials may have had during their certification review of plans.

CMS also conducts post-certification reviews of QHPs offered on the FFE. Agency officials told us that these reviews are focused on high priority and consumer-focused areas to ensure that issuers continue to meet certification standards and that certified QHPs are ready for enrollees to use in the plan year. From 2014 to 2016, CMS officials said they conducted at least one post-certification review for all QHP issuers in FFE states. For example, to ensure that consumers have up to date and accurate formulary information specific to their QHP, since 2014 CMS officials reviewed formulary information and coverage displayed on selected issuer's website. (See table 6 for the number of CMS post-certification reviews by focus area from 2014 to 2016.)

Table 6: Summary of Centers for Medicare & Medicaid Services (CMS) Post-Certification Reviews Conducted in States Using the Federally Facilitated Exchange, 2014-2016

	2014	2015	2016
Total number of qualified health plan (QHP) issuers	182	231	222

Number of QHP issuers that had a post-certification review, by review focus area	2014	2015	2016
Benefits[a]	20	65	214
Essential community providers[b]	102	152	N/A
Formulary[c]	182	231	222
Network adequacy[d]	21	151	144
Provider directory[e]	N/A	229	219

Source: CMS submitted data. I GAO-16-761

Notes: Data reflect CMS oversight of QHPs offered in the individual market through the FFE.

[a]CMS reviews of benefits included verifying that the same information is displayed to consumers (for example, on the issuer's website) as was presented on the health benefits template that issuers submitted to CMS for review at the time of certification.

[b]CMS reviews of essential community providers included the sufficiency of the number and geographic distribution of essential community providers to ensure access for low-income individuals in the QHP service area. In 2016, CMS did not review essential community providers because the agency determined such a review was no longer necessary since it improved the accuracy of its related certification review tool.

[c]CMS reviews of QHP formularies include verifying the active status of the issuer's formulary web site and reviewing formulary coverage for clinical appropriateness based on nationally accepted clinical guidelines.

[d]In 2014, according to CMS, network adequacy reviews were conducted using a qualitative analysis, such as by reviewing network access plans. Beginning in 2015, CMS officials said they utilized a

standard quantitative analysis of network adequacy, assessing whether networks meet a standard that allows for "reasonable access" to a range of services and providers. In 2015 and 2016, according to CMS, they did not conduct network adequacy post-certification reviews for plans offered in the 15 states that utilized the federally facilitated exchange and performed plan management functions through a partnership with CMS.

[e]CMS's review of provider directories included verifying that provider links included on the issuer's website were active and in compliance with standards.

SBEs are responsible for developing a process to certify the QHPs in their state to ensure compliance with federal standards and are responsible for certifying the plans prior to the annual open enrollment period.[3] Exchange officials from the two selected SBE states confirmed that they have a process in place to review and certify QHPs using the federal standards.

Compliance Reviews and Other Ongoing Monitoring Activities

To ensure that QHPs offered on the FFE and SBEs are continuing to meet standards throughout the plan year, CMS and selected states also conduct compliance reviews to varying degrees to ensure compliance with federal and state requirements, among other ongoing monitoring activities. Specifically, CMS conducts compliance reviews of QHPs offered by issuers in the FFE to ensure compliance with exchange-related standards, and SBE states are required to have oversight processes in place to ensure compliance with the same standards. Officials in the selected state departments of insurance we reviewed, both in the FFE and SBE states, state that they oversee issuers selling health insurance in their state to ensure compliance with state requirements and certain other standards.

To identify QHP issuers in the FFE for compliance reviews, CMS uses a risk-based process that leverages information gathered from CMS account managers who work directly with QHP issuers, the certification review process, and the issuers' compliance histories, including their performance in addressing identified issues.[4] These compliance reviews

[3]Part of CMS's oversight of SBEs includes certifying that SBEs have the capacity to fulfill these functions.

[4]CMS assigns an account manager to all QHP issuers participating in the FFE. Account managers serve as the issuer's primary point of contact with the FFE, and provide issuers with clarification and other assistance related to issuers' responsibilities and requirements for participating in the FFE. These account managers also monitor QHP compliance on an ongoing basis to identify specific areas of concern for a particular issuer and provide assistance for resolution.

assess QHPs' compliance with a range of federal exchange standards, such as the requirement for issuers to maintain state licensure. In 2014 and 2015, key priority areas for CMS reviews included whether QHP issuers were covering prescription drugs in accordance with federal regulations and the readability of health plan notices for enrollees. In 2015, CMS conducted compliance reviews of QHPs offered by 32 issuers located in 15 states, representing 14 percent of all issuers offering QHPs on the FFE that year, and, in 2014, CMS conducted compliance reviews of QHPs offered by 23 issuers located in 14 states, representing 13 percent of all issuers offering QHPs on the FFE that year.

As a result of its 2014 compliance reviews, CMS identified a range of issues, including the following examples:

- Some issuers had been excluding information from their QHP provider directories about whether providers were accepting new patients.
- Some issuers had not developed a procedure for resolving certain types of QHP consumer concerns.
- Some issuers sent notices to QHP enrollees that omitted required information explaining how those with limited English proficiency can access language services to understand their health plan notice.

Once compliance reviews are completed, CMS officials said account managers follow up with issuers during the benefit year to monitor and ensure the resolution of identified issues.

CMS requires all states operating SBEs to implement oversight and monitoring policies and procedures for their exchanges as a way to help ensure compliance with federal standards.[5] As part of both the application to implement an SBE and required annual reporting, exchange officials must demonstrate their readiness to conduct plan management and oversight under the same federal standards as required for the FFE, including QHP certification and ensuring ongoing QHP compliance. Exchange officials from our selected states told us they have processes in place to report annually to CMS, and they conduct oversight activities in varied ways. Colorado exchange officials told us they rely on issuers complying with their contracts with the exchange office, which are

[5]45 C.F.R. § 1010 (2015).

required for an issuer to offer QHPs on the exchange and include an agreement on standards such as QHP certification, market conduct, and resolving enrollee concerns. Vermont exchange officials said they have enhanced their oversight and monitoring program.

Additionally, officials we interviewed from our selected states' departments of insurance in the both FFE and SBE states told us that they conduct compliance reviews of QHP issuers in the same way for all issuers offering health plans issued in their state, both on and off the exchange, to ensure compliance with state insurance rules and federal health insurance market standards, which are generally applicable to all plans, whether offered on or off an exchange. The selected states' compliance reviews vary in scope and frequency—for instance, officials from Colorado told us that compliance reviews are conducted on an ad-hoc basis if there is a complaint of potential non-compliance, and officials from Montana told us that they conduct compliance reviews using retrospective data from the previous four to five years, and also investigate federal and state standard violation allegations. Officials from the selected state departments of insurance also told us that they generally conduct their oversight and monitoring activities at the issuer level and therefore were unable to readily separate out data on QHPs or QHP enrollee experiences. An official from one state department of insurance told us that it was important to maintain a level playing field and keep monitoring standards and policies the same for both QHPs and non-QHPs.

Appendix III: CMS Exchange Consumer Casework Data for 2015

CMS operates a Marketplace Call Center to assist the needs of consumers in states that utilize the federally facilitated exchange (FFE). CMS records and tracks issues—referred to as cases—that require action on the part of an issuer, state, or CMS to resolve. According to CMS, cases may include requests, such as those related to an address change, complex questions—for example, relating to tax filings, as well as individual complaints.[1]

In 2015, all cases were assigned to one of four categories—plan and issuer concerns, tax filing issues, eligibility, and legal and administrative—and to subcategories within each category that describe the general nature of the case. CMS officials described the main case categories as follows:

- Plan and Issuer Concerns: This category includes cases where issuers have the capacity or responsibility to resolve cases, such as disenrollment or premium payment.[2]
- Tax Filing Issues: Cases in this category involve enrollee issues related to their tax form. Exchange enrollees are required annually to reconcile the amount of premium tax credit (a federal subsidy that is applied towards qualified health plan premiums) allowed based on reported income with the amount of premium tax credit received in advance.
- Eligibility: Cases in this category primarily consist of issues that consumers experienced prior to enrolling in a qualified health plan, such as technical errors on the exchange Web site, or questions regarding eligibility for the advanced premium tax credit.
- Legal and Administrative: This category includes consumer allegations of fraud or inappropriate release of enrollee information.

[1]According to CMS officials, cases may include requests, such as requests for address changes, requests to terminate coverage, and requests to obtain another copy of a form; general reports of concern, for example, regarding issuer compliance; complex questions, including those related to tax forms; and individual complaints such as those related to denials of coverage.

[2]CMS procedures state that the agency generally only considers matters that require an action on the part of an issuer to be cases after the individual has first sought resolution with their issuer or state department of insurance.

In 2015, most cases were assigned to the plan and issuer category and, within that category, issuer enrollment/disenrollment was the most frequently assigned subcategory. This subcategory included cases of consumers having concerns with being properly enrolled or dis-enrolled by an issuer, such as when an issuer has not processed enrollment information sent from the exchange in a timely manner. The tax filing issues category became the second most frequently assigned category in 2015 when enrollees were required to submit tax information related to their qualified health plan. CMS officials told us that a significant portion of the cases in this category dealt with enrollees requesting an extra copy of their tax form, disagreeing with the information on their tax form, or requesting to update their mailing address. The eligibility category primarily included issues related to consumer requests for special enrollment periods and questions relating to the advanced premium tax credit, according to CMS. Lastly, CMS officials reported that the legal and administrative category includes cases such as a consumer alleging fraud committed against them that is then used in their program integrity review process. Table 7 shows the number and percentage total of cases by subcategory within the four main categories in the casework system in 2015.

Table 7: Centers for Medicare & Medicaid Services (CMS) Exchange Consumer Casework by Category and Subcategory in 2015

Category of consumer cases	Subcategory of consumer cases	2015 Number of cases	2015 Percent of total cases
Plan and issuer concerns[a]	Enrollment/disenrollment issues for issuer action	243,442	17.81
	Cancellation/termination of coverage request	177,105	12.96
	Other[b]	153,541	11.24
	Premium payment	146,722	10.74
	Reinstatement/re-enrollment request	122,616	8.97
	Consumer believes advanced premium tax credit not awarded properly[c]	56,011	4.10
	Medicare overlap issues	30,093	2.20
	Cost-sharing	27,207	1.99
	Special enrollment period (issuer action required)	23,385	1.71
	Eligibility appeals	5,514	0.40
	Issuer customer service	2,701	0.20
	Access to services/benefits	692	0.05
	Claims processing, denials, benefit appeals	326	0.02
	Auto re-enrollment or renewal	206	0.02
	Coordination of benefits	118	0.01
	Marketing complaints	96	0.01
	Provider-originated issues	59	0.00
	Rate review	46	0.00
	Agent/broker-initiated compensation issues	13	0.00
	Quality of care/provider fraud allegations	10	0.00
	Plan and issuer concerns subtotal	989,903	72.43
Tax filing issues[d]	Consumer needs another copy of tax form[d]	219,085	16.03
	Complex research needed	63,925	4.68
	Mailing address correction request	45,439	3.32
	CMS review of tax form requested	3,246	0.98
	Other	511	0.04
	Holding queue	339	0.02

Category of consumer cases	Subcategory of consumer cases	2015 Number of cases	2015 Percent of total cases
	Consumer has not received tax form[d]	45	0.00
	Pending categorization	2	0.00
	Tax filing issues subtotal	**332,589**	**24.34**
Eligibility[e]	Special enrollment period (CMS review required)	31,319	2.29
	Data match	9,034	0.66
	Other	2,681	0.20
	Medicaid/Children's Health Insurance Program decision	546	0.04
	Unable to receive eligibility determination	231	0.02
	Identity verification	99	0.01
	Exemptions	73	0.01
	Advanced premium tax credit and cost sharing reduction	46	0.00
	Appeals	18	0.00
	Exchange decision	8	0.00
	Eligibility subtotal	**44,055**	**3.22**
Legal and administrative[f]	Other	49	0.00
	CMS/call center/web-site performance	10	0.00
	Fraud allegation - CMS review required	7	0.00
	CMS eligibility/appeals contractor performance	4	0.00
	Alleged noncompliance with state or federal rules	3	0.00
	Alleged privacy violations	2	0.00
	Other federal agency performance	2	0.00
	State-based exchange matters	1	0.00
	Legal and administrative subtotal	**78**	**0.01**
Total cases for all categories	**Not applicable**	**1,366,625**	**100.00**

Source: GAO analysis of CMS data as of February 2016. I GAO-16-761

Notes: Cases may include requests, such as those related to an address change; complex questions, for example, relating to tax filings; as well as individual complaints. CMS officials noted that cases also do not represent unique consumers as consumers could have several issues that are logged into different categories, or one case could be for multiple consumers—for example, a family. Two cases that were pending categorization into one of the four main categories were omitted from the table.

[a]Issuers have the capacity or responsibility to resolve cases in the "plan and issuer" category, such as plan termination or premium payment.

[b]Cases in this subcategory primarily related to enrollment issues, terminations, premiums, reinstatements, and enrollment corrections in 2015, according to CMS. Agency officials told us that, beginning in 2016, they modified how the category is being used and comparatively few cases have been recorded as of June 2016.

[c]Advanced premium tax credit is a federal tax credit that is paid in advance and applied towards qualified health plan premiums.

[d]Cases in the "tax filing" category involve consumer issues with the Internal Revenue Service Form 1095-A, entitled the "Health Insurance Marketplace Statement," which the exchanges are required to file for each individual who enrolls in a QHP through an exchange. Exchanges are also required to provide a copy of Form 1095-A to such enrollees so that they may file an accurate tax return and take the premium tax credit or reconcile the credit on their tax returns with advance payments of the premium tax credit.

[e]Cases in the "eligibility" category primarily consist of issues that consumers experienced prior to issuer involvement or outside of the issuer's control, such as technical errors on the exchange website.

[f]Cases in the "legal and administrative" category include a consumer allegation of fraud or inappropriate release of consumer information.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

John Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Patricia Roy, Analyst-in-Charge; Laura Sutton Elsberg; Kate Nast Jones; and Joanna Wu made key contributions to this report. Also contributing were Leia Dickerson; Sandra George; and Laurie Pachter.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts.
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548