



July 2018

# HEALTH INSURANCE EXCHANGES

## HHS Should Enhance Its Management of Open Enrollment Performance

# GAO Highlights

Highlights of [GAO-18-565](#), a report to congressional requesters

## Why GAO Did This Study

Since 2014, millions of consumers have purchased health insurance from the exchanges established by the Patient Protection and Affordable Care Act. Consumers can enroll in coverage during an annual open enrollment period. HHS and others conduct outreach during this period to encourage enrollment and ensure the exchanges' long-term stability. HHS announced changes to its 2018 outreach, prompting concerns that fewer could enroll, potentially harming the exchanges' stability.

GAO was asked to examine outreach and enrollment for the exchanges using [healthcare.gov](#). This report addresses (1) 2018 open enrollment outcomes and any factors that may have affected these outcomes, (2) HHS's outreach efforts for 2018, and (3) HHS's 2018 enrollment goals. GAO reviewed HHS documents and data on 2018 open enrollment results and outreach. GAO also interviewed officials from HHS and 23 stakeholders representing a range of perspectives, including those from 4 navigator organizations, 3 issuers, and 6 insurance departments, to obtain their non-generalizable views on factors that likely affected 2018 enrollment.

## What GAO Recommends

GAO is making three recommendations to HHS, including that it ensure the data it uses for determining navigator organization awards are accurate, set numeric enrollment targets, and assess other aspects of the consumer experience. HHS agreed with two recommendations, but disagreed with the need to set numeric targets. GAO maintains that such action is important.

View [GAO-18-565](#). For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

July 2018

## HEALTH INSURANCE EXCHANGES

### HHS Should Enhance Its Management of Open Enrollment Performance

## What GAO Found

About 8.7 million consumers in 39 states enrolled in individual market health insurance plans offered on the exchanges through [healthcare.gov](#) during the open enrollment period for 2018 coverage. This was 5 percent less than the 9.2 million who enrolled for 2017 and continued a decline in enrollment from a peak of 9.6 million in 2016. Among the 23 stakeholders we interviewed representing a range of perspectives, most reported that plan affordability played a major role in exchange enrollment—both attracting and detracting from enrollment. In 2018, total premiums increased more than expected, and, as a result, plans may have been less affordable for consumers, which likely detracted from enrollment. However, most consumers receive tax credits to reduce their premiums, and stakeholders reported that plans were often more affordable for these consumers because higher premiums resulted in larger tax credits, which likely aided exchange enrollment. Stakeholders had mixed opinions on the effects that other factors, such as the impact of reductions in federal advertising and the shortened open enrollment period, might have had on enrollment.

The Department of Health and Human Services (HHS), which manages [healthcare.gov](#) enrollment, reduced consumer outreach for the 2018 open enrollment period:

- HHS spent 90 percent less on its advertising for 2018 (\$10 million) compared to 2017 (\$100 million). Officials told us that the agency's approach for 2018 was to focus on low-cost, high-performing forms of advertising.
- HHS reduced funding by 42 percent for navigator organizations—which provide in-person enrollment assistance for consumers—spending \$37 million in 2018 compared to \$63 million in 2017 due to a shift in administration priorities. HHS allocated the funding using data that it acknowledged were not reliable in December 2016. The lack of quality data may affect HHS's ability to effectively manage the navigator program.

Unlike in prior years, HHS did not set any numeric targets related to 2018 total [healthcare.gov](#) enrollment; officials told us that they instead focused on enhancing the consumer experience for the open enrollment period. Setting numeric targets would allow HHS to monitor and evaluate its overall performance, a key aspect of federal internal controls. Further, while HHS reported meeting its goal of enhancing the consumer experience, such as by improving [healthcare.gov](#) availability, it did not measure aspects of the consumer experience it had identified as key in 2017, such as successful outreach events. Absent a more complete assessment, HHS may not be able to fully assess its progress toward its goal of enhancing the consumer experience and may miss opportunities to improve other aspects of the consumer experience.

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# Contents

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Letter		1
	Background	5
	Enrollment through Healthcare.gov Was 5 Percent Lower in 2018 than 2017, and Stakeholders Reported That Plan Affordability Likely Played a Major Role in Enrollment	10
	HHS Reduced Consumer Outreach for 2018 and Used Problematic Data to Allocate Navigator Funding	23
	HHS Did Not Set Numeric Enrollment Targets for 2018, and Instead Focused on Enhancing Certain Aspects of Consumers' Experiences	32
	Conclusions	36
	Recommendations for Executive Action	37
	Agency Comments and Our Evaluation	38
Appendix I	GAO List of Factors That May Have Affected 2018 Healthcare.gov Enrollment	42
Appendix II	Information about Stakeholders Interviewed	44
Appendix III	Characteristics of Healthcare.gov Enrollees, 2017 and 2018	45
Appendix IV	Selected Stakeholder Views of Factors Likely Affecting 2018 Enrollment in Healthcare.gov Plans	47
Appendix V	HHS Paid Advertising Expenditures for 2017 and 2018 Open Enrollment Periods	50
Appendix VI	Comments from the Department of Health and Human Services	51
Appendix VII	GAO Contact and Staff Acknowledgments	54

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Tables

Table 1: Health Insurance Exchange Enrollment, 2016 through 2018	12
Table 2: Selected Stakeholder Views of Factors Likely Affecting 2018 Enrollment in Healthcare.gov Plans	47

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Figures

Figure 1: Issuer Projections for the Total Cost of Coverage for Silver Exchange Plan Enrollees, and Changes to Premiums Resulting From the Loss of Federal Cost-Sharing Reduction Payments	8
Figure 2: New and Returning Healthcare.gov Enrollees, 2017 and 2018	13
Figure 3: Average Monthly Premium Costs for Healthcare.gov Enrollees, 2017 and 2018	15
Figure 4: Healthcare.gov Plan Selections by Metal Tier, 2017 and 2018	17
Figure 5: Stakeholder Views on the Likely Effect of Various Factors on 2018 Healthcare.gov Enrollment	22
Figure 6: Changes in HHS Funding for Navigator Organizations for 2018 as Compared to 2017	27
Figure 7: Problematic Data in HHS Calculation of Navigator Organization Awards for 2018	30
Figure 8: Healthcare.gov and Call Center Availability, 2017 and 2018	35

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## Abbreviations

HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act

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July 24, 2018

### Congressional Requesters

Since 2014, millions of consumers have purchased individual market health insurance plans through the health insurance exchanges—or marketplaces—established under the Patient Protection and Affordable Care Act (PPACA).<sup>1</sup> PPACA directed each state to establish an exchange—referred to as a state-based exchange—or elect to use the federally facilitated exchange established by the Department of Health and Human Services (HHS).<sup>2</sup> Each year the exchanges offer an open enrollment period during which eligible consumers may enroll in or change their coverage. Consumers enroll in the federally facilitated exchange through HHS’s healthcare.gov website, and some state-based exchanges have chosen to also use healthcare.gov for enrollment.<sup>3</sup> HHS facilitates enrollment for states that use the healthcare.gov website and is required to perform outreach and education activities to educate consumers about the exchanges and to encourage enrollment.<sup>4</sup>

Some health policy and insurance industry experts assert that the long-term stability of the exchanges will require sufficient levels of enrollment,

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<sup>1</sup>See PPACA, Pub. L. No. 111-148, §§ 1311(b), 124 Stat. 119, 173 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010.

<sup>2</sup>For 2017 and 2018, 34 states used the federally facilitated exchange and 17 used state-based exchanges. States using the federally facilitated exchange in these years were: Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The term “state” in this report includes the District of Columbia. HHS refers to exchanges as marketplaces.

<sup>3</sup>Thirty-nine states used the healthcare.gov website for 2017 and 2018 enrollment, including the 34 states that used the federally facilitated exchange and 5 states with state-based exchanges: Arkansas, Kentucky, New Mexico, Nevada, and Oregon. The remaining 12 states used their own websites for enrollment.

In order to enroll in coverage, individuals must complete an application and meet certain eligibility requirements defined by PPACA—for example, they must be a U.S. citizen or national or otherwise be lawfully present in the United States.

<sup>4</sup>45 C.F.R. § 155.205(e) (2017).

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including enrollment among young or otherwise healthy individuals who might be less likely to purchase health insurance. Specifically, bringing these younger, healthier individuals into the exchanges would reduce adverse selection—where less-healthy individuals who expect or plan for high use of health care services disproportionately enroll in coverage leading to higher premiums that can ultimately discourage healthy individuals from enrolling. Some experts have also asserted that consumer outreach plays a key role in reducing adverse selection. For example, while sick individuals may be motivated to enroll in exchange coverage to obtain their needed treatment, healthier individuals may need to be reminded and encouraged to do so—which these experts contend is the role of effective outreach.<sup>5</sup>

Beginning with the open enrollment period for 2014 coverage—the exchanges' first open enrollment period—HHS conducted broad public relations and advertising outreach to familiarize the public with the availability of exchange coverage. However, beginning in 2017, HHS announced several changes to its exchange outreach activities. For example, it suspended certain planned marketing and advertising during the final week of the 2017 open enrollment period and scaled back its outreach efforts for the 2018 open enrollment period.<sup>6</sup> In addition, the agency reduced the length of the 2018 open enrollment period for states using healthcare.gov for enrollment, from about 13 weeks to about 6 weeks.<sup>7</sup> These changes led to questions among various stakeholders, such as certain research and advocacy organizations, about whether the number and health needs of those enrolled in the exchanges would meet expectations or present challenges to the long-term stability of health insurance markets. However, other research and advocacy organizations

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<sup>5</sup>See, for example, National Association of Insurance Commissioners, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* (Washington, D.C.: 2011); Georgetown University Health Policy Institute Center on Health Insurance Reforms, *Strategies to Stabilize the Affordable Care Act Marketplaces: Lessons from Medicare* (Washington, D.C.: August 2016); and Covered California, *Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets* (Sacramento, Ca.: September 2017).

<sup>6</sup>The HHS Office of Inspector General reviewed changes HHS made to its outreach efforts during the open enrollment period for 2017 coverage. See HHS Office of Inspector General, *Review of The Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts, OEI-12-17-00290* (Washington, D.C.: Oct. 25, 2017).

<sup>7</sup>The open enrollment period for 2017 coverage was November 1, 2016, through January 31, 2017, and for 2018 coverage was November 1, 2017, through December 15, 2017.

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contend that these and other changes collectively helped to simplify or reduce unnecessary costs of the program. For the 2018 open enrollment period, for example, HHS emphasized the availability of agents and brokers that could assist consumers with enrollment and simplified its enrollment process by allowing consumers to enroll in healthcare.gov coverage through certain partner websites.

You asked us to examine how 2018 open enrollment period outcomes compared to those for 2017 and to review how HHS's outreach efforts affected 2018 enrollment. In this report, we examine:

1. how 2018 open enrollment outcomes for healthcare.gov compared with those for 2017, and any factors that affected 2018 enrollment;
2. how HHS's outreach efforts for the 2018 open enrollment period compared to those for 2017; and
3. HHS's 2018 enrollment goals for the health insurance exchanges.

To examine how 2018 open enrollment outcomes compared with those for 2017 and any factors that may have affected 2018 enrollment, we examined HHS data on 2017 and 2018 open enrollment period results for the 39 states that used the federal healthcare.gov website for enrollment. We also reviewed HHS data on open enrollment period results for 2016 for additional context. To assess these data for reliability, we reviewed supporting documentation, examined trends reported in these data, and interviewed HHS officials. We found the data sufficiently reliable for the purposes of our reporting objective. We also analyzed HHS information, interviewed health policy experts, and reviewed publications by these experts related to exchange enrollment to identify factors that had the potential to affect 2018 enrollment. (See app. I for a list of these factors.) Using this list of factors, we conducted structured interviews with officials from 23 stakeholder organizations to gather their viewpoints as to whether and how these or other factors affected 2018 health insurance exchange enrollment. We selected organizations to reflect a wide range of perspectives and included HHS-funded navigator organizations that provide in-person consumer enrollment assistance, issuers, state insurance departments, professional trade organizations, research and



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advocacy organizations, and state-based exchanges.<sup>8</sup> We identified themes for reporting according to our analysis of the frequency with which the stakeholders we interviewed identified factors as having a certain impact.<sup>9</sup> While we selected stakeholders to include a broad range of perspectives, their viewpoints are not generalizable beyond the 23 organizations included in our interviews. Additional information about the stakeholders we interviewed is presented in appendix II.

To examine how HHS's outreach efforts for the 2018 open enrollment period compared to those for 2017, we obtained and reviewed HHS data from both periods, including its budgets for advertising and navigator funding, and its allocation of that funding to various advertising techniques and to navigator organizations. We also reviewed associated HHS documentation, including a study on the effectiveness of advertising during the 2017 open enrollment period and documentation of HHS's navigator organization funding process. In addition, we reviewed relevant PPACA provisions and HHS regulations and guidance and interviewed officials from HHS to learn more about the agency's outreach efforts for both open enrollment periods. We interviewed representatives from our selected navigator organizations and a group that hosts an online community for navigators to obtain additional context. We reviewed self-reported data that all navigator organizations provided to HHS on the number of outreach events they performed during the 2017 and 2018 open enrollment periods. We also reviewed information HHS published about its outreach for both open enrollment periods, and compared HHS's outreach efforts to relevant standards for internal control in the federal government.<sup>10</sup>

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<sup>8</sup>Navigator organizations, among other things, carry out public education activities and help consumers enroll in health insurance plans offered through the exchange. HHS awards financial assistance to navigator organizations that provide these services in states using the federally facilitated exchange. While states may fund navigator programs, for the purposes of this report we only refer to HHS-funded navigator organizations. 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.

<sup>9</sup>In this report, the term "most stakeholders" refers to at least 15; "many stakeholders" refers to at least 8; and "some stakeholders" refers to at least 3 stakeholders.

<sup>10</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

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To examine HHS's 2018 enrollment goals for the health insurance exchanges, we interviewed HHS officials to understand their goals for the enrollment period and compared them to relevant federal internal control standards. To examine the agency's performance with respect to its goals, we reviewed relevant performance data. To assess these data for reliability, we interviewed agency officials and examined trends in the data. We found the data sufficiently reliable for the purposes of our reporting objective.

We conducted this performance audit from September 2017 to July 2018 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.

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## Background

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### Considerations for Exchange Enrollment and Plan Selection

Qualified health plans sold through the exchanges must meet certain minimum requirements, including those related to benefits coverage.<sup>11</sup> Beyond these requirements, many elements of plans can vary, including their cost and availability. Those who opt to enroll in a plan generally pay for their health care in two ways: (1) a premium to purchase the insurance, and (2) cost-sharing for the particular health services they receive (for example, deductibles, coinsurance, and co-payments).<sup>12</sup>

### Metal Tiers

Qualified health plans are offered at one of four metal tiers that reflect the out-of-pocket costs that may be incurred by a consumer. These tiers correspond to the plan's actuarial value—a measure of the relative

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<sup>11</sup>For example, qualified health plans offered on an exchange 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 other things.

<sup>12</sup>Issuers set proposed premium rates and cost-sharing based on their expected amount of claims and other expenses, which may include an expected positive margin. State insurance commissioners review issuers' proposed rates for the upcoming year to ensure that they comply with applicable regulations. Although states have primary responsibility for overseeing health insurance, certain federal regulations may apply.

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generosity of a plan's benefits that is expressed as a percentage of the covered medical expenses expected to be paid, on average, by the issuer for a standard population and set of allowed charges for in-network providers.<sup>13</sup> In general, as actuarial value increases, consumer cost-sharing decreases. The actuarial values of the metal tiers are: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent).<sup>14</sup> If an issuer sells a qualified health plan on an exchange, it must offer at least one plan at the silver level and one plan at the gold level; issuers are not required to offer bronze or platinum plans.

## Financial Assistance

Individuals purchasing coverage through the exchanges may be eligible, depending on their incomes, to receive financial assistance to offset the costs of their coverage. According to HHS, more than 80 percent of enrollees obtained financial assistance in the first half of 2017, which came in the form of premium tax credits or cost-sharing reductions.<sup>15</sup>

- **Premium tax credits.** These are designed to reduce an eligible individual's premium costs, and can either be paid in advance on a monthly basis to an enrollee's issuer—referred to as advance premium tax credits—or received after filing federal income taxes for the prior year.<sup>16</sup> To be eligible for premium tax credits, enrollees must generally have household incomes of at least 100, but no more than 400, percent of the federal poverty level.<sup>17</sup> The amount of the premium tax credit varies based on enrollees' income relative to the

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<sup>13</sup>Health plans typically establish a network of providers with which they negotiate reimbursement rates. The actuarial value for each plan is calculated assuming all services are obtained within the network. Consumers who choose to access services from providers outside their plans' networks may incur higher costs.

<sup>14</sup>Catastrophic plans are also available to certain individuals who are under 30 years old or meet other criteria. These plans have low monthly premiums and high deductibles, and enrollees must pay for most of their routine medical expenses.

<sup>15</sup>Department of Health and Human Services, *First Half of 2017 Average Effectuated Enrollment Data*, (Washington, D.C.: Dec. 13, 2017).

<sup>16</sup>Premium tax credits are refundable, which means that eligible consumers may receive the full amount of the premium tax credit at the time they file their federal income taxes for the preceding year, or they may be paid in advance, on a monthly basis—concurrent with monthly premium payments—to an issuer on behalf of an eligible individual to offset premiums owed. For this report, the term "premium tax credits" refers to both advance premium tax credits and the credits received during the income tax filing process.

<sup>17</sup>For 2018, the federal poverty level is \$25,100 for a family of four residing in the contiguous United States or the District of Columbia; amounts are higher for those living in Alaska and Hawaii.

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cost of premiums for their local benchmark plan—which is the second lowest cost silver plan available—but consumers do not need to be enrolled in the benchmark plan in order to be eligible for these tax credits.<sup>18</sup>

- **Cost-sharing reductions.** Enrollees who qualify for premium tax credits, have household incomes between 100 and 250 percent of the federal poverty level, and enroll in a silver tier plan may also be eligible to receive cost-sharing reductions, which lower enrollees' deductibles, coinsurance, and co-payments.<sup>19</sup>

To reimburse issuers for reduced cost-sharing from qualified enrollees, HHS made payments to issuers (referred to as cost-sharing reduction payments) until October 2017, when it discontinued these payments.<sup>20</sup> Despite HHS's decision to discontinue cost-sharing reduction payments, issuers are still required under PPACA to offer cost-sharing reductions to eligible enrollees. Since consumers who receive these reductions are generally enrolled in silver plans, insurance commissioners in most states instructed the issuers in their states to increase 2018 premiums for silver plans offered on the exchanges to reflect the discontinued federal payments.<sup>21</sup> This has been referred to as "silver-loading" and resulted in substantial increases in exchange-based silver plan premiums for 2018.<sup>22</sup>

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<sup>18</sup>The premium tax credit available to consumers does not increase if they enroll in exchange plans with higher premiums than the local benchmark plan. In such cases, consumers are responsible not only for their required contribution but also for the difference in premiums. Similarly, if a consumer chooses to enroll in an exchange plan with lower premiums than the local benchmark plan premium, then the consumer's premium tax credit would also generally remain the same, so the consumer would pay less for that plan. The tax credit cannot, however, exceed the total value of the premium. Because most consumers enrolling in exchange plans receive advance premium tax credits, most consumers' out-of-pocket premium costs are lower than the advertised cost of premiums.

<sup>19</sup>In addition, certain American Indian and Alaskan Natives who purchase exchange plans of any metal tier may be eligible for cost-sharing reductions.

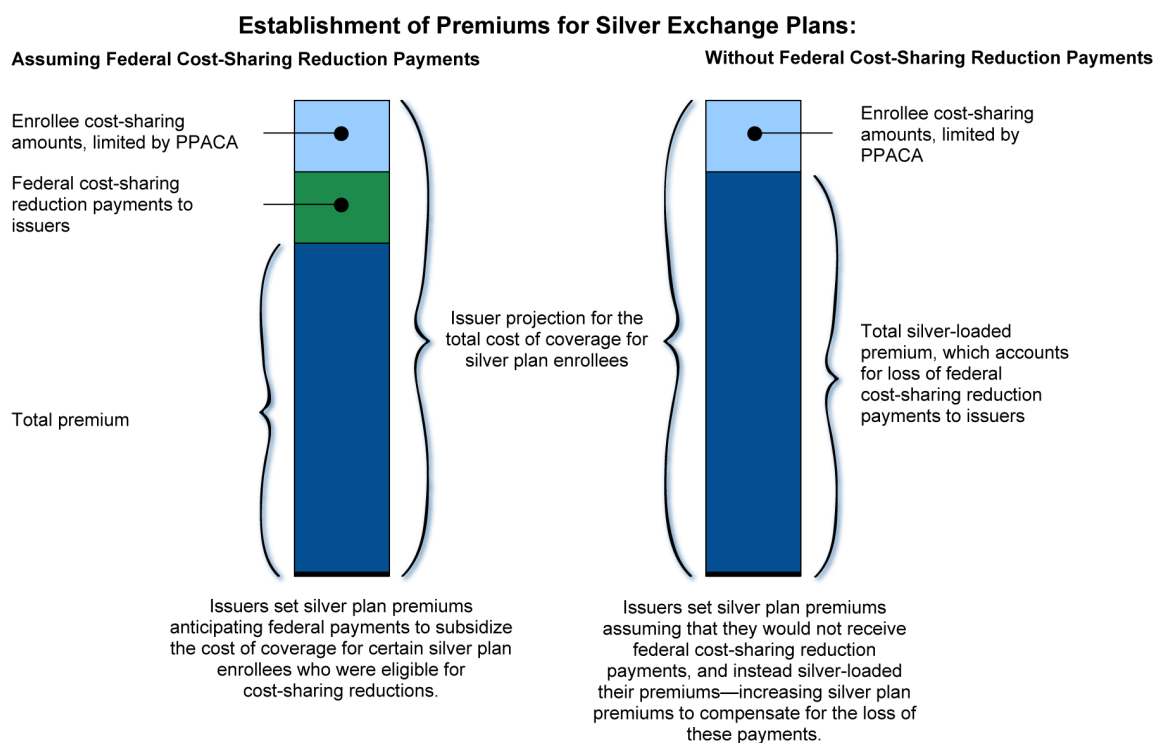
<sup>20</sup>In October 2017, HHS announced that it was discontinuing payments to issuers for cost-sharing reductions due to the lack of an appropriation for the payments. Litigation challenging this decision is ongoing.

<sup>21</sup>S. Corlette, K. Lucia, and M. Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments," *To the Point*, The Commonwealth Fund, Oct. 27, 2017.

<sup>22</sup>For example, HHS reported that premiums for a benchmark plan available to a 27-year old increased an average of 37 percent from 2017 to 2018. HHS ASPE Research Brief: *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchanges* (Washington, D.C.: Oct. 30, 2017).

(See fig.1.) Because the amount of an eligible enrollee’s premium tax credit is based on the premium for the enrollee’s local benchmark plan (the second lowest cost silver plan available to an enrollee), the value of this form of financial assistance also increased significantly for 2018.<sup>23</sup>

**Figure 1: Issuer Projections for the Total Cost of Coverage for Silver Exchange Plan Enrollees, and Changes to Premiums Resulting From the Loss of Federal Cost-Sharing Reduction Payments**



Source: GAO. | GAO-18-565

Note: The Patient Protection and Affordable Care Act (PPACA) requires issuers to offer certain enrollees—including silver plan enrollees with incomes between 100 and 250 percent of the federal poverty level and certain American Indian and Alaskan Natives—coverage with reduced cost-sharing. These cost-sharing reductions lower enrollees’ payments for out-of-pocket expenses, such as deductibles, coinsurance, and copayments. In October 2017, the Department of Health and Human Services announced that it was discontinuing payments to issuers for cost-sharing reductions due to the lack of an appropriation for the payments. Issuers are still required under PPACA to offer cost-sharing reductions to eligible enrollees.

<sup>23</sup>In April 2018, the Congressional Budget Office reported that increased premiums and corresponding increases in premium tax credits stemming from the elimination of federal cost-sharing reduction payments is likely to increase federal spending by \$44 billion over prior estimates for the 2018 to 2027 period. Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028* (Washington, D.C.: Apr. 2018).

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## Plan Availability

As we have previously reported, the number and type of plans available in the health insurance exchanges varies from year to year.<sup>24</sup> Issuers can add new plans and adjust or discontinue existing plans from year to year, as long as the plans meet certain minimum requirements—such as covering essential health benefits. Issuers can also extend or restrict the locations in which they offer plans. According to HHS, while individuals seeking 2018 coverage were able to select from an average of 25 plans across the various metal tiers, 29 percent of consumers were able to select from plans from only one issuer.<sup>25</sup>

## Exchange Outreach

HHS performs outreach to increase awareness of the open enrollment period and facilitate enrollment among healthcare.gov consumers—including those new to the exchanges as well as those returning to renew their coverage. Outreach to these different types of enrollees can vary. For example, while outreach to those new to the exchanges may focus more on the importance of having insurance, outreach to existing enrollees may focus on encouraging them to go back to the exchange to shop for the best option.

## Consumer Assistance

All exchanges are required to carry out certain functions to assist consumers with their applications for enrollment and financial assistance, among other things. HHS requires exchanges to operate a website and toll-free call center to address the needs of consumers requesting assistance with enrollment, and to conduct outreach and educational activities to help consumers make informed decisions about their health insurance options.<sup>26</sup> HHS administers the federal healthcare.gov website, which allows consumers in states using the website for enrollment to directly compare health plans based on a variety of factors, such as premiums and provider networks. HHS also operates a Marketplace Call Center to respond to consumer questions about enrollment. Consumers may apply for coverage through the call center, the website, via mail, or in person (in some areas), with assistance from navigator organizations or agents and brokers.

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<sup>24</sup>See, for example, GAO, *Private Health Insurance: The Range of Premiums and Plan Availability for Individuals in 2014 and 2015*, [GAO-15-687](#) (Washington, D.C.: Aug. 10, 2015).

<sup>25</sup>HHS ASPE Research Brief: *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchanges* (Washington, D.C.: Oct. 30, 2017).

<sup>26</sup>45 C.F.R. § 155.205 (2017).

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- **Navigators.** PPACA required all exchanges to establish “navigator” programs to conduct public education activities to raise awareness of the availability of coverage available through the exchanges, among other things.<sup>27</sup> As part of HHS’s funding agreement with navigator organizations in states using the federally facilitated exchange, HHS requires them to maintain relationships with consumers who are uninsured or underinsured.<sup>28</sup> They must also examine consumers’ eligibility for other government health programs, such as Medicaid, and provide other assistance to consumers—for example, by helping them understand how to access their coverage.<sup>29</sup>
  - **Agents and Brokers.** Licensed by states, agents and brokers may also provide assistance to those seeking to enroll in a health plan sold on the exchanges; however, they are generally paid by issuers. They may sell products for one issuer from which they receive a salary, or from a variety of issuers and be paid a commission for each plan they sell.

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## Enrollment through Healthcare.gov Was 5 Percent Lower in 2018 than 2017, and Stakeholders Reported That Plan Affordability Likely Played a Major Role in Enrollment

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<sup>27</sup>42 U.S.C. § 18031(i). Navigators may not be health insurers or take compensation from insurers for selling health policies.

<sup>28</sup>See Department of Health and Human Services, *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces*, CA-NAV-15-001 (Apr. 15, 2015). On July 10, 2018, HHS issued a navigator funding opportunity announcement for 2019, which includes the 2019 open enrollment period.

<sup>29</sup>45 C.F.R. § 155.210(e)(9) (2017).

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## Exchange Enrollment through Healthcare.gov Was 5 Percent Lower in 2018 than 2017

About 8.7 million consumers enrolled in healthcare.gov plans during the open enrollment period for 2018 coverage, 5 percent less than the 9.2 million who enrolled for 2017.<sup>30</sup> This decline continues a trend from 2016, when a peak of 9.6 million consumers enrolled in such plans.<sup>31</sup> Since that peak, enrollment has decreased by 9 percent. Enrollment in plans sold by state-based exchanges that use their own enrollment website has remained relatively stable during the same time period, with just over 3.0 million enrollees each year since 2016. Overall, enrollment in federal and state exchanges has declined 7 percent from a peak of nearly 12.7 million enrollees in 2016, largely driven by the decrease in enrollment in exchanges using healthcare.gov. (See table 1.) HHS officials told us that they did not want to speculate on the specific factors that affected enrollment this year, but noted that the exchanges are designed for consumers to utilize as needed, which includes degrees of fluctuation from year to year. A decreased demand for exchange-based insurance could be influenced by increases in the numbers of people with other types of health coverage, such as coverage through other public programs, or that which is sponsored by their employers.<sup>32</sup>

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<sup>30</sup>In 2017 and 2018, 39 states used healthcare.gov for enrollment—including 34 that used the federally facilitated exchange and 5 that used a state-based exchange.

<sup>31</sup>This decline in healthcare.gov enrollment persisted despite Kentucky adding over 80,000 individuals to healthcare.gov enrollment totals for 2017 and 2018 as it switched in 2017 from being a state-based exchange.

<sup>32</sup>Federal data sources show that, from the time of the 2016 open enrollment period to that for 2018, the proportion of the population without health insurance has remained stable while the number of those covered through certain public programs has grown, and employment levels have increased, which may have resulted in increased levels of employer sponsored coverage. Specifically, the most recent data available from HHS show that the uninsured rate in 2017 (9.1 percent) was not significantly different from that for 2016, and that enrollment in Medicaid and the Children's Health Insurance Program—public programs designed to provide health insurance coverage to certain low income individuals—increased 3 percent, from 71.8 million in December 2015 to 74.0 million in December 2017. In addition, Bureau of Labor Statistics data show that the seasonally adjusted unemployment rate was lower during the 2018 open enrollment period (4.1 percent in both November and December 2017) than it had been at any time since the health insurance exchanges began offering coverage in 2014. See HHS, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017* (Atlanta, Ga.: May 22, 2018); HHS, *Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (Baltimore, Md.: Feb. 29, 2016); HHS, *December 2017 and January 2018 Preliminary Medicaid and CHIP Monthly Enrollment Report*; and U.S. Bureau of Labor Statistics, *Bureau of Labor and Statistics, Graphics for Economic News Releases: Civilian Unemployment Rate*, accessed May 2, 2018, <https://www.bls.gov/charts/employment-situation/civilian-unemployment-rate.htm>.



**Table 1: Health Insurance Exchange Enrollment, 2016 through 2018**

Enrollment website	Plan selections during open enrollment			Percentage change in enrollment		
	2016	2017	2018	2016-2017	2017-2018	2016-2018
Healthcare.gov	9,625,982	9,201,805	8,743,642	-4	-5	-9
State-based exchange	3,055,892	3,014,198	3,006,533	-1	0	-2
<b>Total</b>	<b>12,681,874</b>	<b>12,216,003</b>	<b>11,750,175</b>	<b>-4</b>	<b>-4</b>	<b>-7</b>

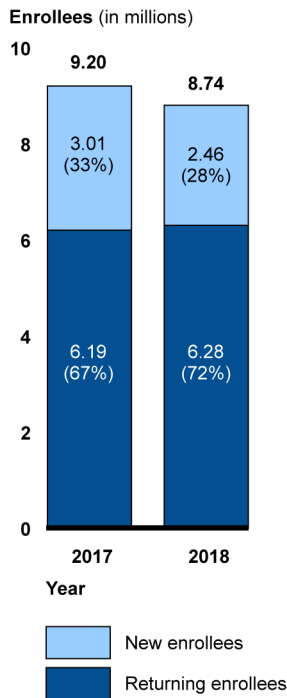
Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Percentages do not sum due to rounding. For 2016, 38 states used healthcare.gov for enrollment, and 13 state-based exchanges, including Kentucky, used their own website for enrollment. For 2017 and 2018, 39 states, including Kentucky, used healthcare.gov and 12 state-based exchanges used their own website for enrollment. The state-based exchange total for 2016 includes Kentucky, which had 93,666 enrollees, and the healthcare.gov totals for 2017 and 2018 include Kentucky with 81,155 and 89,569 enrollees, respectively. For 2016 and 2017, the data reflect enrollment as of February 1, 2016, and January 31, 2017, respectively. For 2018, the data for states using healthcare.gov reflect enrollment as of December 23, 2017, and for state-based exchanges, reflect enrollment as of the end of each state's open enrollment period and any cleanup for late exchange activity, which varied by state.

Enrollees who were new to healthcare.gov coverage comprised a smaller proportion of total enrollees in 2018 than in 2017, continuing a trend seen in prior years. The proportion of new enrollees decreased from 33 percent (3 million) in 2017 to 28 percent (2.5 million) in 2018 (see fig. 2).<sup>33</sup> Some stakeholders noted the importance of enrolling new, healthy enrollees each year to maintain the long-term viability of the exchanges. However, other stakeholders noted that they had expected the number and proportion of new enrollees to decrease over time because a large majority of those who wanted coverage and were eligible for financial assistance had likely already enrolled. The increasing proportion of enrollees who return to the exchanges for their coverage could also demonstrate their need for or satisfaction with this coverage option.

<sup>33</sup>HHS changed the way it defined new enrollees between 2017 and 2018. For 2017, those who enrolled during the open enrollment period and did not have healthcare.gov coverage on or after November 1, 2016—the first day of the open enrollment period—were considered new enrollees. For 2018, those who enrolled during the open enrollment period and did not have coverage through a healthcare.gov plan through December 31, 2017, were considered new enrollees. HHS reported that this change would have a marginal effect on the classification of consumers as either new or returning.

**Figure 2: New and Returning Healthcare.gov Enrollees, 2017 and 2018**



Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Data reflect enrollment for the 39 states using healthcare.gov as of January 31, 2017 (for 2017), and December 23, 2017 (for 2018). The Department of Health and Human Services (HHS) changed the way it defined new enrollees between 2017 and 2018. For 2017, new enrollees included those who enrolled during the open enrollment period and did not have coverage through a healthcare.gov plan on or after November 1, 2016—the first day of the 2017 open enrollment period. For 2018, new enrollees included those who enrolled during the open enrollment period and did not have coverage through a healthcare.gov plan through December 31, 2017. HHS reported that this change would have a marginal effect on the classification of consumers as either new or returning.

The demographic characteristics of enrollees remained largely constant from 2017 through 2018. For example, the proportion of enrollees with household incomes of 100 to 250 percent of the federal poverty level remained similar at 71 percent in 2017 and 70 percent in 2018. In addition, the proportion of enrollees whose households were located in rural areas was 18 percent in both years.<sup>34</sup> However, the proportion of healthcare.gov enrollees aged 55 and older increased from 27 percent in

<sup>34</sup>HHS classifies household locations based on its Federal Office of Rural Health Policy's definition of rural and urban areas, which incorporates Rural-Urban Commuting Area codes.

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2017 to 29 percent in 2018. Appendix III provides detailed information on the characteristics of enrollees in 2017 and 2018.

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### Stakeholders Reported That Plan Affordability Likely Played a Major Role in 2018 Exchange Enrollment and Plan Selection

According to stakeholders we interviewed, plan affordability likely played a major role in 2018 exchange enrollment—both attracting and detracting from enrollment—and enrollees’ plan selection. In 2018, premiums across all healthcare.gov plans increased an average of 30 percent—more than expected given overall health cost trends. As a result of these premium increases, plans were less affordable in 2018 compared to 2017 for exchange consumers without advance premium tax credits (15 percent in 2018).<sup>35</sup> One driver of these premium increases was the elimination of federal cost-sharing reduction payments to issuers in late 2017, which resulted in larger premium increases for silver tier plans (the most popular healthcare.gov metal tier). For example, among enrollees who did not use advance premium tax credits, the average monthly premium amount paid for silver plans increased 45 percent (from \$424 in 2017 to \$614 in 2018). Average premiums for these enrollees also increased for bronze and gold plans, but not by as much—22 percent for bronze plans (from \$374 in 2017 to \$455 in 2018) and 23 percent for gold plans (from \$509 in 2017 to \$628 in 2018). Most stakeholders we interviewed told us the decreased affordability of plans likely resulted in lower enrollment in exchange plans for these consumers. Some stakeholders we interviewed reported personally encouraging consumers who were not eligible for premium tax credits to purchase their coverage off of the exchanges, where they could often purchase the same health insurance plan for a lower price.

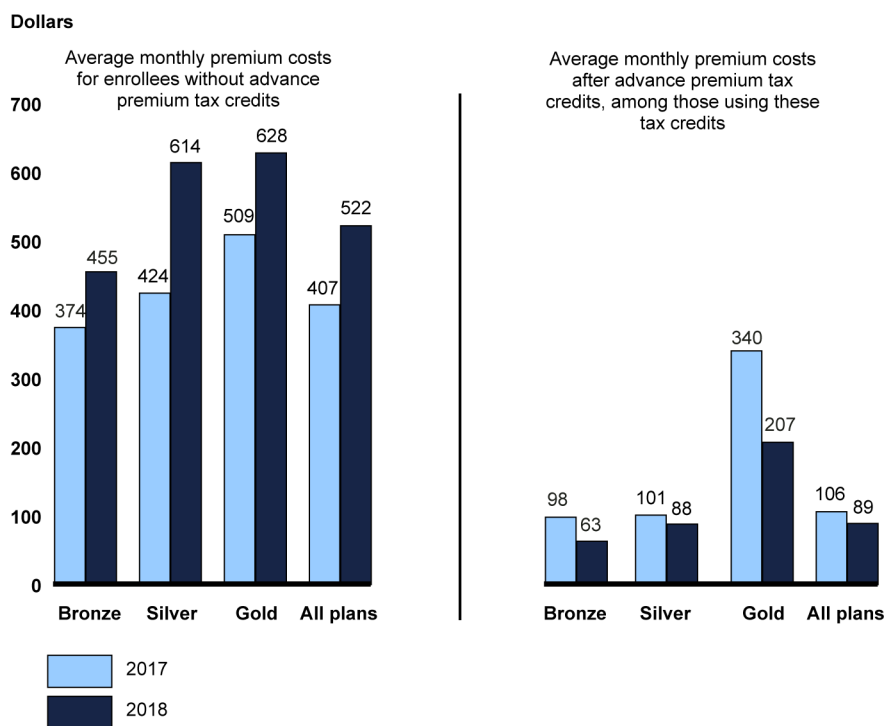
However, despite overall premium increases, plans became more affordable for the more than 85 percent of exchange consumers who used advance premium tax credits, because the value of the premium tax credits increased significantly in order to compensate for the higher premiums of silver plans. For example, the average value of monthly advance premium tax credits for those enrolled in any exchange plan increased 44 percent, from \$383 in 2017 to \$550 in 2018—the largest increase in the program’s history. As a result, enrollees who used advance premium tax credits faced lower net monthly premiums on average in 2018 than they had in 2017—specifically, enrollees’ average

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<sup>35</sup>The proportion of healthcare.gov enrollees without advance premium tax credits was 16 percent for 2017 and 15 percent for 2018. A portion of these consumers may have deferred claiming the premium tax credit until they file their individual tax returns for the preceding year.

net monthly premiums across all plans decreased 16 percent from \$106 in 2017 to \$89 in 2018. According to most stakeholders we interviewed, the enhanced affordability of net monthly premiums among consumers who used advance premium tax credits likely encouraged enrollment among this group. (See fig. 3).

**Figure 3: Average Monthly Premium Costs for Healthcare.gov Enrollees, 2017 and 2018**



Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Average premiums, including those that are net of monthly advance premium tax credits, are average per-person premium amounts, weighted by healthcare.gov plan enrollment during the open enrollment period for 2017 and 2018. Data reflect enrollment in healthcare.gov for 39 states using healthcare.gov as of January 31, 2017 (for 2017), and December 23, 2017 (for 2018).

Stakeholders we interviewed also noted that plan affordability likely played a major role in enrollees' plan selection, including the metal tier of their coverage. This finding is consistent with our prior work which showed that plan cost—including premiums—is a driving factor in

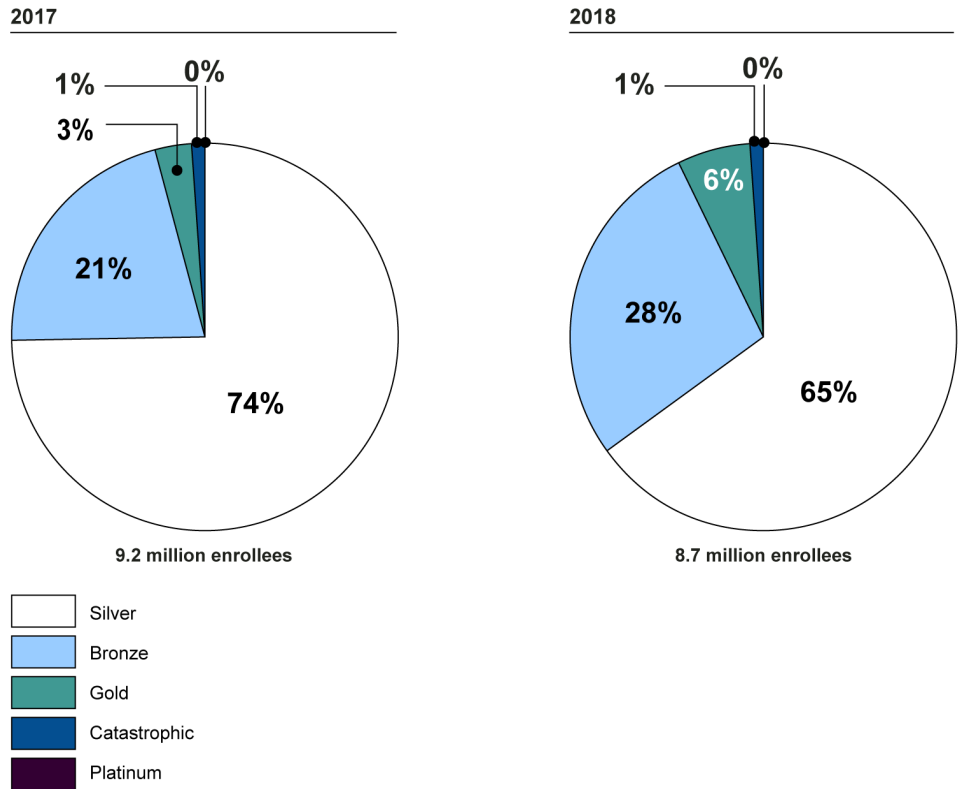
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exchange enrollees' selection of a plan.<sup>36</sup> Specifically, we found that while silver plans remained the most popular healthcare.gov metal tier, covering 65 percent of all enrollees in 2018, this proportion decreased 9 percentage points from 2017 as more enrollees selected bronze and gold plans. (See fig. 4.)

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<sup>36</sup>GAO, *Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plan, Although Some Concerns Exist*, [GAO-16-761](#) (Washington, D.C.: Sept. 12, 2016).

**Figure 4: Healthcare.gov Plan Selections by Metal Tier, 2017 and 2018**



Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Data reflect enrollment in healthcare.gov for 39 states using healthcare.gov as of January 31, 2017 (for 2017), and December 23, 2017 (for 2018). Metal tiers reflect plans' actuarial values—a measure of the relative generosity of the plan's benefits that is expressed as a percentage of the covered medical expenses to be paid, on average; as the actuarial value increases, consumer cost-sharing decreases. The actuarial values of the metal tiers are: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). Catastrophic plans have low monthly premiums and high deductibles, and are only available to certain individuals who are under 30 years old or meet other criteria; premium tax credits are not available for the purchase of these plans.

Stakeholders reported that consumers using advance premium tax credits benefitted from enhanced purchasing power in 2018 due to the impact of silver loading, which likely served as a driving factor in these consumers'

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plan selections.<sup>37</sup> Specifically, they noted that the increased availability of free bronze and low-cost gold plans (after tax credits were applied) for such consumers likely explained why many enrollees moved from silver to bronze or gold plans for 2018.<sup>38</sup> While average monthly net premiums paid by these consumers decreased overall from 2017 to 2018 due to the tax credits, the changes were most pronounced for those enrolled in bronze or gold plans (which decreased 36 and 39 percent, respectively), compared to silver plans (which decreased 13 percent). Separately, the enhanced affordability of gold plans, along with the richer benefits they offer, likely led some consumers to move from silver to gold plans in 2018. While the average monthly net premium amount paid for gold plans in 2018 (\$207) remained higher than that for less generous silver plans (\$88) among those using advance premium tax credits, it was nearly 40 percent lower than the average net premium for gold plans in 2017 (\$340). Stakeholders also reported that consumers in some areas were able to access gold plans for a lower cost than silver plans. The proportion of enrollees in gold plans using advance premium tax credits increased from 49 percent to 74 percent—signaling that many enrollees used their higher tax credits to enroll in richer gold plan coverage.

As the proportion of enrollees with silver plans declined for 2018, so too did the proportion of enrollees with cost-sharing reductions—which are generally only available to those with silver plans.<sup>39</sup> Specifically, 54 percent of healthcare.gov enrollees received these subsidies in 2018, 6

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<sup>37</sup>Those not using advance premium tax credits may also have had reasons to switch to bronze or gold plans for 2018, given that silver plan premiums increased at a higher rate, on average, than for other plans. Those wishing to pay lower premiums may have selected bronze plans, for which the 2018 average premium (\$455) was less than that for silver plans (\$614). Or, they may have selected more generous gold plans, for which the 2018 average premium (\$628) was similar to that for silver plans (\$614).

<sup>38</sup>Others have also reported about the increased availability of free bronze and low-cost gold plans. See, for example, Avalere, *Most Counties Will Have Free 2018 Exchange Plans for Low-Income Enrollees* (Washington, D.C.; Nov. 2, 2017); Bipartisan Policy Center, *Stabilizing the Individual Insurance Market: What Happened and What Next?*, (Washington, D.C.: Mar. 2018); Kaiser Family Foundation, *How Premiums are Changing in 2018* (Menlo Park, Ca.: Nov. 14, 2017); and Oliver Wyman Health, *Availability of Free Bronze ACA Plans on the Rise* (Oct. 31, 2017).

<sup>39</sup>Certain American Indian or Alaskan Native enrollees who purchase exchange plans of any metal tier may be eligible for cost-sharing reductions, whereas all others must be enrolled in silver plans in order to receive these subsidies.

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percentage points lower than the 60 percent who received these subsidies in 2017.<sup>40</sup>

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## Stakeholders Reported That a Variety of Other Factors Likely Affected 2018 Enrollment

Stakeholders we interviewed reported that a variety of factors other than plan affordability also likely affected 2018 exchange enrollment, but opinions on the impact of each factor were mixed. Specifically, most stakeholders we interviewed, including all 4 navigator organizations and 3 professional trade organizations, reported that consumer confusion about PPACA and its status likely played a major role in detracting from 2018 healthcare.gov enrollment.<sup>41</sup> Some of these stakeholders attributed consumers' confusion about the exchanges to efforts to repeal and replace PPACA. In addition, many stakeholders attributed consumer confusion to the Administration's negative statements about PPACA. Further, many stakeholders reported that as a result of the public debate during 2017 over whether to repeal and replace PPACA many consumers had questions about whether the law had been repealed and whether insurance coverage was still available through the exchanges.<sup>42</sup> However, other stakeholders reported that this debate likely did not affect enrollment and consumers who were in need of exchange-based coverage were likely able to find the information they required to enroll. In addition, many stakeholders noted that consumer understanding and enrollment was aided through increased outreach and education events conducted by many groups, including some state and local governments,

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<sup>40</sup>While the total proportion of those with cost-sharing reductions decreased, enrollees at the lowest income levels eligible for cost-sharing reductions may have been encouraged to enroll in a silver plan in order to receive this benefit. The proportion of silver plan enrollees with household incomes of 100 to 150 percent of the federal poverty level increased from 42 percent in 2017 to 47 percent in 2018, while the proportion of bronze plan enrollees with this income level decreased from 15 percent in 2017 to 12 percent in 2018.

<sup>41</sup>Stakeholders reported that in addition to detracting from consumers' interest in enrolling, the presence of consumer confusion about these issues took time for navigators, issuers, and others to address prior to being able to engage consumers in the process of enrollment.

<sup>42</sup>Others reported confusion among consumers about whether forgoing 2018 health insurance coverage would result in a tax penalty. PPACA included an individual mandate that requires most individuals to have health insurance coverage or pay a tax penalty. However, during the 2018 open enrollment period, legislation repealing the tax penalty imposed for failure to comply with PPACA's individual mandate was considered and subsequently enacted. See Pub. L. No. 115-97, § 11081, 131 Stat. 2044 (Dec. 22, 2017). As a result, beginning January 1, 2019, individuals who fail to comply with the individual mandate will no longer face a tax penalty.



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hospitals, issuers, and community groups. Many stakeholders also noted that the volume of exchange-related news increased significantly before and during the open enrollment period for 2018 coverage, in part due to the ongoing political debate about the future of the exchanges. These stakeholders agreed that this increase in reporting about the exchanges likely resulted in increased consumer awareness and enrollment, even in cases where the coverage negatively portrayed the exchanges.

Many stakeholders also said that reductions in HHS outreach and advertising of the open enrollment period likely detracted from 2018 enrollment, in part because any reduction in promoting enrollment detracts from overall consumer awareness and understanding of the program and its open enrollment period.<sup>43</sup> In particular, some stakeholders reported that outreach and advertising are especially important for increasing new enrollment, especially among younger and healthier consumers whose enrollment can help ensure the long-term stability of the exchanges. However, other stakeholders reported that these reductions likely had no effect on enrollment, noting that most consumers who needed exchange-based coverage were already enrolled in it and were well aware of the program, and also noting that enrollment in 2018 did not dramatically change compared with that of 2017.

Stakeholders we interviewed were largely divided on the effects of other factors on 2018 healthcare.gov enrollment, including the shorter 6-week open enrollment period. For example, about half of the stakeholders said that the shorter open enrollment period likely led fewer to enroll due to lack of consumer awareness of the new deadline, as well as to challenges related to the reduced capacity of those helping consumers to enroll. However, many others said that the shorter open enrollment period likely had no effect. In particular, some of these stakeholders noted that enrollment in 2018 was similar to that for 2017 and that during prior open enrollment periods the majority of consumers had enrolled by December

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<sup>43</sup>For example, during the first 6 weeks of the 2017 open enrollment period, HHS tweeted about the program more than 5 times the amount it did during the same 6 weeks of the 2018 open enrollment period to encourage consumers to enroll in exchange plans. Specifically, the HHS, Centers for Medicare & Medicaid Services, and healthcare.gov Twitter accounts collectively tweeted about the program at least 144 times from November 1 through December 15, 2016, and 27 times from November 1 through December 15, 2017, encouraging consumers to enroll in healthcare.gov coverage. Twitter is a social networking website that allows users to share and receive information through short messages known as “tweets.” Users can “follow” other users to subscribe to their tweets.

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15, as this was the deadline for coverage that began in January.<sup>44</sup> Figure 5 displays the range of stakeholder views on factors affecting 2018 healthcare.gov enrollment, and appendix IV provides selected stakeholder views of factors affecting 2018 healthcare.gov enrollment.

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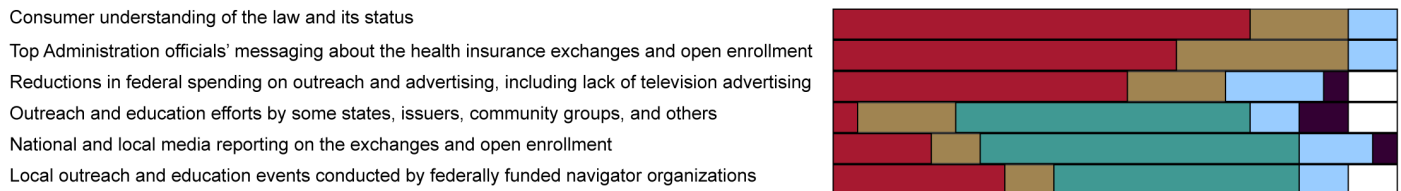
<sup>44</sup>While the healthcare.gov open enrollment period for prior years was longer than for 2018, the deadline for enrolling in coverage that began on January 1 of the following year has been December 15 since the open enrollment period for 2015 coverage. Previously, HHS planned to shorten the open enrollment period to 6 weeks beginning with the open enrollment period for 2019 coverage, but in April 2017, HHS announced plans to implement this change 1 year early. 82 Fed. Reg. 18,346 (Apr. 18, 2017).

**Figure 5: Stakeholder Views on the Likely Effect of Various Factors on 2018 Healthcare.gov Enrollment**

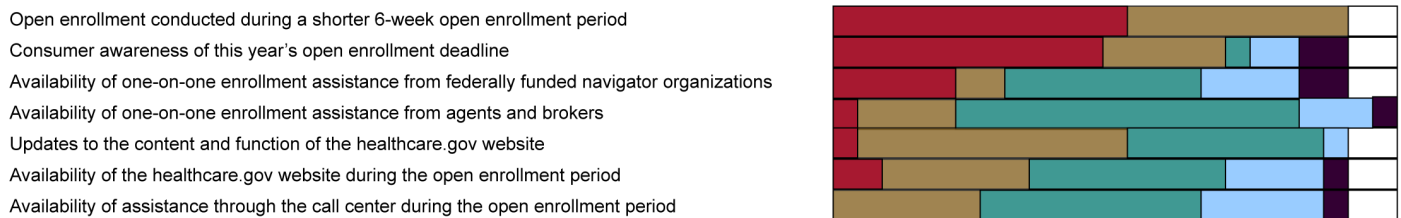
**Factors related to plan affordability and choice**



**Factors related to consumer outreach and understanding**



**Factors related to enrollment and consumer assistance**



Source: GAO analysis of 23 stakeholder interviews. | GAO-18-565

Note: Colors reflect the frequency with which stakeholders reported the effect. Stakeholders were selected to reflect a wide range of perspectives, and included Department of Health and Human Services-funded navigator organizations that provide in-person consumer enrollment assistance, issuers, state insurance departments, professional trade organizations, research and advocacy organizations, and state-based exchanges.

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## HHS Reduced Consumer Outreach for 2018 and Used Problematic Data to Allocate Navigator Funding

HHS reduced its consumer outreach—including paid advertising and navigator funding—for the 2018 open enrollment period. Further, HHS allocated the navigator funding using a narrower approach and problematic data, including consumer application data that it acknowledged were unreliable and navigator organization-reported goal data that were based on an unclear description of the goal, and which HHS and navigator organizations likely interpreted differently.

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## HHS Reduced Paid Advertising

HHS reduced the amount it spent on paid advertising for the 2018 open enrollment period by 90 percent, spending \$10 million as compared to the \$100 million it spent for the 2017 open enrollment period.<sup>45</sup> HHS officials reported that their 2018 advertising approach was a success, noting that they cut wasteful spending on advertising, which resulted in a more cost-effective approach.<sup>46</sup> HHS officials told us that the agency elected to reduce funding for paid advertising to better align with its spending on paid advertising for the Medicare open enrollment period. According to the officials, HHS targeted its reduced funding toward low-cost forms of paid advertising that HHS studies showed were effective in driving enrollment, and that could be targeted to specific populations, such as individuals aged 18 to 34 and individuals who had previously visited healthcare.gov. For example, for 2018, HHS spent about 40 percent of its paid advertising budget on two forms of advertising aimed at reaching these populations.

Specifically, HHS spent \$1.2 million on the creation of two digital advertising videos that were targeted to potential young enrollees, and \$2.7 million on search advertising, in which Internet search engines displayed a link to healthcare.gov when individuals used relevant search terms. HHS followed up with individuals that visited the link to encourage them to enroll. Agency officials said they focused some of their paid

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<sup>45</sup>HHS spending on paid advertising for the 2018 open enrollment period was also 80 percent less than it was for the 2016 open enrollment period, when it spent \$51 million on paid advertising.

<sup>46</sup>In total, HHS spent about \$1 per enrollee on advertising for 2018, compared to about \$11 for 2017 and \$5 for 2016. While this may suggest that HHS's advertising was more cost-effective than in prior years, some stakeholders we interviewed reported that this type of calculation does not reflect the importance of spending on outreach to increase enrollment among young and healthy consumers as a means to ensure the long-term stability of the exchange.

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advertising on individuals aged 18 to 34 because in the prior open enrollment period many individuals in this age range enrolled after December 15—the deadline for the 2018 open enrollment period. HHS officials said they did not use paid television advertising because it was too expensive and because it was not optimal for attracting young enrollees—although a 2017 HHS study found this was one of the most effective forms of paid advertising for enrolling new and returning individuals during the prior open enrollment period. See appendix V for HHS’s expenditures for paid advertising for the 2017 and 2018 open enrollment periods.

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### HHS Reduced Navigator Funding and Used a Narrower Approach and Problematic Data to Allocate It

HHS reduced navigator funding by 42 percent for 2018, spending \$37 million compared to the \$63 million it spent for 2017.<sup>47</sup> According to HHS officials, the agency reduced this funding due to a shift in the Administration’s priorities. For the 2018 open enrollment period, HHS planned to rely more heavily on agents and brokers—another source of in-person consumer assistance, who, unlike navigator organizations that are funded through federal grants, are generally paid for by the issuers they represent. HHS took steps to highlight their availability to help consumers and enable consumers to enroll through them.<sup>48</sup> For example, for the 2018 open enrollment period, HHS made a new “Help on Demand” tool available on healthcare.gov that connected consumers directly to local agents or brokers. HHS also developed a streamlined enrollment process for those enrolling through agents and brokers.

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<sup>47</sup>Under its funding agreement, HHS has awarded navigator organizations funding annually for periods that begin in September of the prior year and include the open enrollment period—for example, funding for 2018 was awarded in September 2017. HHS awarded \$37 million in navigator funding for 2018, which was a 45 percent reduction compared to the \$67 million it awarded for 2016.

On July 10, 2018, HHS announced that it planned to award \$10 million in funding for navigators for 2019, reflecting a 73 percent reduction in funding from 2018.

<sup>48</sup>Stakeholders we interviewed noted that agents and brokers have different incentives and roles than navigators. Whereas navigators are tasked with providing impartial information about health insurance options to traditionally underserved populations, including assisting those with limited English proficiency or complex enrollment and financial circumstances, agents and brokers may be able to provide more detailed information about specific insurance plans, such as about provider networks or prescription drug coverage offered through exchange plans by issuers with whom they work.

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HHS also changed its approach for allocating the navigator funding to focus on a narrower measure of navigator organization performance than it had used in the past. According to HHS officials, in prior years, HHS awarded funding based on navigator organizations' performance on a variety of tasks, such as the extent to which navigator organizations met their self-imposed goals for numbers of public outreach events and individuals assisted with applications for exchange coverage and selection of exchange plans.<sup>49</sup> HHS officials said the agency previously also took state-specific factors, such as the number of uninsured individuals in a state, into account when awarding funding. HHS calculated preliminary navigator funding awards for 2018 using this approach.<sup>50</sup> However, according to HHS officials, the agency later decided to change both its budget and approach for allocating navigator funding for 2018 to hold navigator organizations more accountable for the number of individuals they enrolled in exchange plans. In its new funding allocation approach, rather than taking into account navigator organization performance on a variety of tasks, HHS only considered performance in achieving one goal—the number of individuals each navigator organization planned to assist with selecting or enrolling in exchange plans for 2017 coverage. In implementing this new approach, HHS compared the number of enrollees whose 2017 exchange coverage applications included navigator identification numbers with each navigator organization's self-imposed goal. For navigator organizations that did not appear to meet their goals, HHS decreased their preliminary 2018 award

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<sup>49</sup>As part of their applications for HHS funding for 2018 and prior years, navigator organizations were required to include estimates of the numbers of individuals they expected to serve, including their goals for the numbers of 1) public outreach events they planned to host, 2) individuals they planned to assist with applications for exchange coverage and selection of exchange plans, 3) one-on-one appointments with consumers they planned to conduct, and 4) any additional metrics they would like HHS to use in evaluating their progress. HHS stated in its funding agreement that it would evaluate navigator organizations' performance in meeting these goals as part of its award calculation for each year.

<sup>50</sup>HHS sent letters to navigator organizations in May 2017—before HHS made the decision to decrease the total amount of navigator funding to \$37 million—containing preliminary award amounts for 2018, noting the maximum potential awards they could expect to receive. The letters contained relatively minor funding changes reflective of the overall slight decrease in navigator funding planned at the time, from \$63 million for 2017 to \$60 million for 2018.

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amounts proportionately.<sup>51</sup> For navigator organizations that appeared to meet or exceed their goals, HHS left their preliminary 2018 award amounts unchanged. Based on this change in approach, HHS offered 81 of its 98 navigator organizations less funding for 2018, with decreases ranging from less than 1 percent to 98 percent of 2017 funding levels.<sup>52</sup> HHS offered 4 of the 98 navigator organizations increased funding and 13 the same level of funding they received for 2017 (see fig. 6).

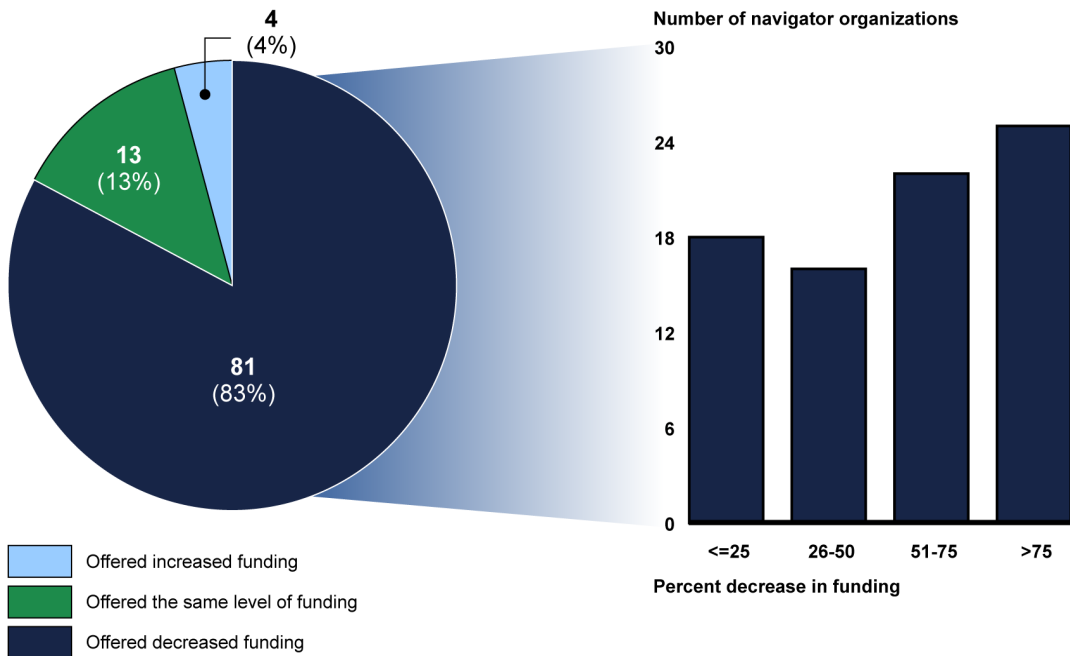
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<sup>51</sup>Funding decreases were subject to a \$10,000 minimum award. For example, a navigator organization that stated it would assist 100 individuals with exchange enrollment for 2017 but only enrolled 50 individuals as per HHS data—that is, missing its goal by 50 percent—would receive 50 percent of its 2018 preliminary award amount or \$10,000, whichever was greater.

<sup>52</sup>Our count of navigator organizations includes some that participated in multiple states. We consider these organizations to be distinct for our purposes because they received separate funding for each state in which they participated. Under this counting approach, 103 navigator organizations received funding for 2017. However, only 98 were offered funding for 2018 as 5—1 single-state organization and 2 dual-state organizations— withdrew from participation in the navigator program in September 2017.

**Figure 6: Changes in HHS Funding for Navigator Organizations for 2018 as Compared to 2017**

Total of 98 navigator organizations



Source: GAO analysis of Department of Health and Human Services (HHS) data. | GAO-18-565

Note: Navigator organizations, among other things, carry out public education activities and help consumers enroll in a health insurance plan offered through the exchange. HHS awards financial assistance to navigator organizations that provide these services in states using the federally facilitated exchange. This figure compares HHS navigator funding for 2018, which included the 2018 open enrollment period for exchange coverage, with funding for 2017, which included the 2017 open enrollment period. HHS offered \$37 million to 98 navigator organizations for 2018. Eight of the navigator organizations that were offered decreased funding voluntarily withdrew from the program. (Our count of navigator organizations includes some that participated in multiple states; we consider these organizations to be distinct for our purposes because they received separate funding for each state in which they participated.)

We found that the data HHS used for its revised funding approach were problematic for multiple reasons. In particular, prior to using the 2017 consumer application data as part of its 2018 funding calculations, HHS had acknowledged that these data were unreliable, in part because navigators were not consistently entering their identification numbers into applications during the 2017 open enrollment period. Specifically, HHS stated in a December 9, 2016, email to navigator organizations that the application data were unreliable and thus could not be used. Over 4 million individuals had enrolled in 2017 coverage by December 10, 2016, so it is likely that many of the applications that HHS used in its 2018 funding calculation included incomplete or inaccurate information with respect to navigator assistance. HHS provided guidance to navigator



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organizations in the December 2016 email on the importance of, and locations for, entering identification numbers into applications to help improve the reliability of the data. However, some data reliability issues may have remained throughout the 2018 open enrollment period, as two of the navigator organizations we interviewed reported ongoing challenges entering navigator identification numbers into applications during this period. For example, representatives from one navigator organization reported that the application field where navigators enter their identification number was at times pre-populated with an agent or broker's identification number.<sup>53</sup> Consumer application data may therefore still be unreliable for use in HHS navigator funding decisions that would be expected later this year for 2019.

Moreover, the 2017 goal data that HHS used in its funding calculation were also problematic because HHS described the goal in an unclear manner when it asked navigator organizations to set their goals. As a result, HHS's interpretation of the goal was likely different than how it was interpreted and established by navigator organizations.<sup>54</sup> Specifically, in its award application instructions, HHS asked navigator organizations to provide a goal for the number of individuals that they "expected to be assisted with selecting/enrolling in [exchange plans] (including re-enrollments)" but HHS did not provide guidance to navigator organizations on how it would interpret the goal.<sup>55</sup> HHS officials told us that they wanted to allow navigator organizations full discretion in setting their goals, since the organizations know their communities best. In its funding calculation, HHS interpreted this goal as the number of individuals navigator organizations planned to enroll in exchange plans. However, as written in the award application instructions, the goal could be interpreted more broadly, because not all individuals whom navigators assist with the selection of exchange plans ultimately apply and enroll in

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<sup>53</sup>Beginning with the 2019 open enrollment period, HHS officials plan to allow applications to include identification numbers from multiple consumer assisters, such as navigators, agents, and brokers, to reflect the fact that consumers may seek assistance with enrollment from multiple entities.

<sup>54</sup>In addition, we found that one navigator organization did not provide HHS with the goal HHS used in its funding calculation. Without this information, HHS awarded the navigator organization the same level of funding for 2018 that it had received for 2017.

<sup>55</sup>Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces, *2016 Non-Competing Continuation Application Instructions* (Apr. 14, 2016).

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coverage. Representatives from one navigator organization we spoke with said they did interpret this goal more broadly than how it was ultimately interpreted by HHS—and thus set it as the number of consumers they planned to assist in a variety of ways, not limiting it to those they expected to assist through to the final step of enrollment in coverage. The navigator organization therefore set a higher goal than it otherwise would have, had it understood HHS’s interpretation of the goal, and ultimately received a decrease in funding for 2018.

As a result, we found that two of the three inputs in HHS’s calculation of 2018 navigator organization awards were problematic (see fig. 7).

**Figure 7: Problematic Data in HHS Calculation of Navigator Organization Awards for 2018**



= problematic

Source: GAO analysis of information from the Department of Health and Human Services (HHS). | GAO-18-565

Notes: Navigator organization awards for 2017 and 2018 included the 2017 and 2018 open enrollment periods, respectively.

<sup>a</sup>To calculate preliminary 2018 award amounts, HHS evaluated navigator organizations' 2017 performance based on a variety of factors, including the extent to which navigator organizations met various goals. HHS also took state-specific factors into account, such as the number of uninsured individuals in a state.

HHS's reduced funding and revised funding allocation approach resulted in a range of implications for navigator organizations.<sup>56</sup> According to HHS officials, eight of the navigator organizations that were offered reduced funding for 2018—with reductions ranging from 50 to 98 percent of 2017 funding levels—declined their awards and withdrew from the program. HHS reported asking the remaining navigator organizations to focus on re-enrolling consumers who had coverage in 2017 and resided in areas where issuers reduced or eliminated plan offerings for 2018, and informing consumers about the shortened open enrollment period for 2018 coverage. Representatives of the navigator community group we interviewed reported that many navigator organizations did focus their resources on enrollment and cut back on outreach efforts, particularly in rural areas. According to self-reported navigator organization data provided by HHS, navigator organizations collectively reported conducting 68 percent fewer outreach events during the 2018 open enrollment period

<sup>56</sup>Although, as of January 2018, none of the navigator organizations we interviewed were aware of how their 2018 funding amounts were determined, they generally understood that HHS's revised funding approach focused on the number of consumers they enrolled in exchange coverage.

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as compared to the 2017 period.<sup>57</sup> Representatives from the navigator organizations we interviewed also reported making changes to their operations; for example, officials from one of the navigator organizations reported cutting staff and rural office locations. Officials from another navigator organization said that they focused their efforts on contacting prior exchange enrollees to assist them with re-enrollment, instead of finding and enrolling new consumers, and de-prioritized assistance with Medicaid enrollment. The three navigator organizations we spoke with that had funding cuts for 2018 also reported that their ability to perform the full range of navigator duties during the rest of the year would be compromised because they needed to make additional cuts in their operations—such as reducing staff and providing less targeted assistance to underserved populations—in order to reduce total costs. One of the three navigator organizations reported that it may go out of business at the end of the 2018 award year.

HHS's narrower approach to awarding funding; lack of reliable, complete data on the extent to which navigator organizations enrolled individuals in exchange plans; and lack of clear guidance to navigator organizations on how to set their goals could hamper the agency's ability to use the program to meet its objectives. Federal internal control standards state that management should use quality information to achieve the agency's objectives, such as by using relevant, reliable data for decision-making.<sup>58</sup> Without reliable performance data and accurate goals, HHS will be unable to measure the effectiveness of the navigator program and take informed action as necessary. Further, because HHS calculated awards using problematic data, navigator organizations may have received awards that did not accurately reflect their performance in enrolling individuals in exchange plans. Additionally, HHS's narrow focus on exchange enrollment limited its ability to make decisions based on relevant information. Moving forward, this may affect navigator organizations' interests and abilities in providing a full range of services to their communities, including underserved populations. This, in turn, could

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<sup>57</sup>Navigator organizations likely also performed fewer outreach events due to the shorter length of the 2018 open enrollment period.

<sup>58</sup>See [GAO-14-704G](#).

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affect HHS's ability to meet its objectives, such as its objective of improving Americans' access to health care.<sup>59</sup>

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## HHS Did Not Set Numeric Enrollment Targets for 2018, and Instead Focused on Enhancing Certain Aspects of Consumers' Experiences

HHS did not set any numeric enrollment targets for 2018 related to total healthcare.gov enrollment, as it had in prior years. In prior years, HHS used numeric targets to monitor enrollment progress during the open enrollment period and focus its resources on those consumers that it believed had a high potential to enroll in exchange coverage. For example, HHS established a target of enrolling a total of 13.8 million individuals during the 2017 open enrollment period and also set numeric enrollment targets for 15 regional markets that the agency identified as presenting strong opportunities for meaningful enrollment increases, partly due to having a high percentage of eligible uninsured individuals.<sup>60</sup> HHS used these regional target markets to focus its outreach, travel, and collaborations with local partners. According to agency officials, during prior open enrollment periods, HHS monitored its performance with respect to its targets and revised its outreach efforts in order to better meet its goals.

According to federal internal control standards, agencies should design control activities to achieve their objectives, such as by establishing and monitoring performance measures.<sup>61</sup> HHS has recognized the importance of these internal controls by requiring state-based exchanges to develop performance measures and report on their progress. Without developing numeric targets for healthcare.gov enrollment, HHS's ability to both perform high level assessments of its performance and progress and to make critical decisions about how to use its resources is hampered. HHS may also be unable to ensure that it meets its objectives—including its current objective of improving Americans' access to health care, including

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<sup>59</sup>Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Strategic Plan FY 2018-2022*, accessed May 9, 2018, <https://www.hhs.gov/about/strategic-plan/index.html>.

<sup>60</sup>HHS developed these targets using available data on the number of exchange enrollees, number of uninsured individuals, and changes in access to employer-sponsored insurance, Medicaid, and other public sources of coverage. See, for example, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Enrollment Projections for 2017*, ASPE Issue Brief (Oct. 19, 2016); Centers for Medicare and Medicaid Services, *CMS Announces Target Markets for Open Enrollment 2017* (Baltimore, Md.: Oct. 27, 2016).

<sup>61</sup>See [GAO-14-704G](#).

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by stabilizing the market and implementing policies that increase the mix of younger and healthier consumers purchasing plans through the individual market.<sup>62</sup>

HHS leadership decided against setting numeric enrollment targets for the 2018 open enrollment period and instead focused on a goal of enhancing the consumer experience, according to HHS officials. Specifically, HHS officials measured the consumer experience based on its assessment of healthcare.gov availability and functionality, and call center availability and customer satisfaction. HHS officials told us that they selected these measures of the consumer experience because healthcare.gov and the call center represent two of the largest channels through which consumers interact with the exchange. HHS reported meeting its goal based on consumers' improved experiences with these two channels, some of which had been problematic in the past.<sup>63</sup> (See fig. 8.)

**Healthcare.gov.** According to HHS officials, the healthcare.gov website achieved enhanced availability and functionality for the 2018 open enrollment period, continuing a trend in improvements over prior years. While HHS scheduled similar periods of healthcare.gov downtime for maintenance in 2017 and 2018, the website had less total downtime during the 2018 open enrollment period because the agency needed to conduct less maintenance.<sup>64</sup> HHS officials attributed the increased availability in part to an operating system upgrade and comprehensive testing of the website that they conducted before the 2018 open enrollment period began. In addition, unlike prior years, HHS officials said that the agency published scheduled maintenance information for 2018 to reduce scheduling conflicts for consumers and groups providing enrollment assistance. HHS also reported enhancing the functionality of the website for the 2018 open enrollment period, including by adding new tools, such as

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<sup>62</sup>Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Strategic Plan FY 2018-2022*, accessed May 9, 2018, <https://www.hhs.gov/about/strategic-plan/index.html>.

<sup>63</sup>For example, see GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, [GAO-15-238](#) (Washington, D.C.: Mar. 4, 2015).

<sup>64</sup>HHS scheduled healthcare.gov maintenance windows on Sundays from midnight to 12pm for 2018 and on Sundays from midnight to 10am or midnight to 12pm for 2017. During downtime for maintenance, enrollment cannot take place through healthcare.gov.

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a “help on demand” feature that links consumers with a local agent or broker willing to assist them, as well as updated content that included more plain language. Many stakeholders we interviewed told us that healthcare.gov functioned well during the open enrollment period and was more available than it had been in prior years.

**Call Center Assistance.** According to HHS officials, the call center reduced wait times and improved customer satisfaction scores in 2018, continuing a trend in improvements over prior years. HHS officials reported average wait times of 5 minutes, 38 seconds for the 2018 open enrollment period—almost four minutes shorter than the average wait time experienced during a comparable timeframe of the 2017 open enrollment period.<sup>65</sup> HHS officials attributed this reduction in wait times to improvements in efficiency, including scripts that used fewer words and generated fewer follow-up questions. In addition, there was a modest reduction in call center volume during similar timeframes of the 2017 and 2018 open enrollment periods.<sup>66</sup> Officials from many stakeholders we interviewed reported that call center assistance was more readily available this year than it had been in prior years. HHS officials also reported an average call center customer satisfaction score of 90 percent in 2018 compared to 85 percent in 2017, based on surveys conducted at the end of customer calls.<sup>67</sup>

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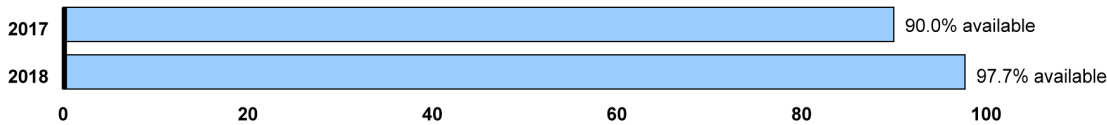
<sup>65</sup>Specifically, the average call center wait time experienced from November 1, 2016, to December 15, 2016, was 9 minutes, 34 seconds. Average call center wait times for the 2018 open enrollment period also reflect improvement from the 10 minutes, 31 seconds average wait experienced during the 2016 open enrollment period.

<sup>66</sup>Specifically, call center volume was 4.65 million from November 1, 2016, through December 10, 2016, and 4.36 million from November 1, 2017, through December 9, 2017.

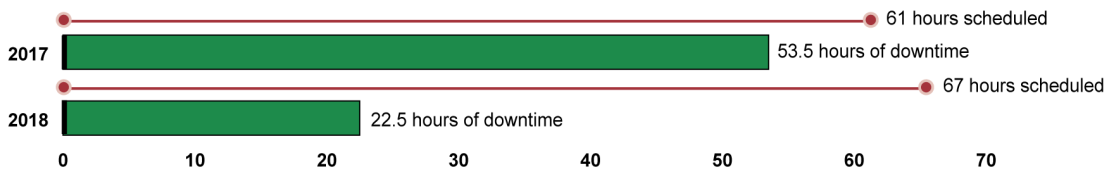
<sup>67</sup>Customer satisfaction scores for the 2018 open enrollment period also reflect improvement from the 2016 open enrollment period, when satisfaction scores averaged 78 percent.

**Figure 8: Healthcare.gov and Call Center Availability, 2017 and 2018**

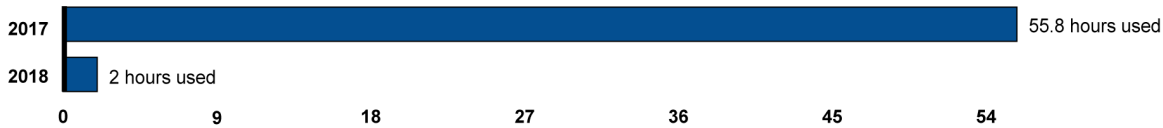
Healthcare.gov availability<sup>a</sup>



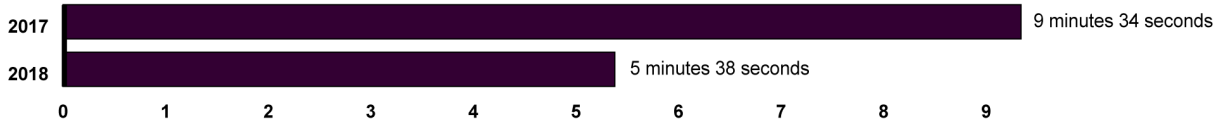
Healthcare.gov maintenance scheduled<sup>b</sup> and downtime<sup>c</sup>



Use of healthcare.gov waiting rooms<sup>d</sup>



Call center wait times (overall average)



Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Data reflect healthcare.gov and call center availability during similar time periods of the 2017 and 2018 open enrollment periods: from November 1 through December 15 of both 2016 and 2017 for call center availability and 7am on November 1 through 3am on December 16 of both 2016 and 2017 for healthcare.gov availability. This reflects the full open enrollment period for 2018, but only part of the open enrollment period for 2017, which ran until January 31, 2017.

<sup>a</sup>Healthcare.gov availability reflects the total amount of time the website was fully available for enrollment, which excludes the time during which the website was down for maintenance and waiting rooms were used.

<sup>b</sup>Healthcare.gov scheduled maintenance reflects time periods during which HHS and, typically, federal partners, are authorized to perform system maintenance.

<sup>c</sup>Healthcare.gov maintenance downtime is the amount of time that HHS or other partners performed healthcare.gov maintenance.

<sup>d</sup>Healthcare.gov waiting rooms are used when officials determine that the website has reached capacity. At that point, the agency asks a consumer entering the website to wait until capacity is available.

Although HHS officials reported that the agency met its goal of enhancing specific aspects of the consumer experience for the 2018 open enrollment period, HHS narrowly defined its goal and excluded certain



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aspects of the consumer experience that it had identified as key as recently as 2017. More specifically, in 2017, HHS reported that successful outreach and education events and the availability of in-person consumer assistance, such as that provided by navigators to help consumers understand plan options, were key aspects of the consumer experience.<sup>68</sup> However, HHS did not include these key items when measuring progress toward their 2018 goal of enhancing the consumer experience. Federal internal control standards state that agencies should identify risks that affect their defined objectives and use quality information to achieve these objectives, including by identifying the information required to achieve the objectives and address related risks.<sup>69</sup> By excluding key aspects of the consumer experience in its evaluation of its performance, HHS's assessment of the consumer experience may be incomplete. For example, as noted above, some stakeholders we interviewed told us that consumer confusion likely detracted from enrollment for 2018, and some linked this outcome to HHS's reduced role in promoting exchange enrollment, including navigator support, which may have resulted in less in-person consumer assistance through navigators. HHS's assessment of the consumer experience, which focused only on consumers who used the website or reached out to the call center during open enrollment, did not account for the experiences of those who interacted with the health insurance exchanges through other channels, such as through navigators or agents and brokers.

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## Conclusions

Some experts have raised questions about the long-term stability of the exchanges absent sufficient enrollment, including among young and healthy consumers. To encourage exchange enrollment, HHS has traditionally conducted a broad outreach and education campaign, including funding navigator organizations that provide in-person enrollment assistance. For the 2018 open enrollment period, HHS reduced its support of navigator organizations and changed its approach for allocating navigator funding to focus on exchange enrollment alone. HHS allocated the funding based on performance data that were problematic for multiple reasons, including because some of the underlying data were unreliable. As a result, navigator organizations received funding that reflected a more limited evaluation of their

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<sup>68</sup>Department of Health and Human Services, Centers for Medicare and Medicaid Services, *2017 CMS Assister Summit Agenda*, (Baltimore, Md. June 28, 2017).

<sup>69</sup>See [GAO-14-704G](#).

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performance than HHS had used in the past, and that may not have accurately reflected their performance. This raises the risk that navigator organizations will decrease the priority they place on fulfilling a range of other duties for which they are responsible, including providing assistance to traditionally underserved populations, which some navigator organizations we interviewed reported they had either decreased or planned to decrease due to reduced funding. HHS's lack of complete and reliable data on navigator organization performance hampers the agency's ability to make appropriately informed decisions about funding. Moreover, its focus on enrollment alone in awarding funding may affect navigator organizations' ability to fulfill the full range of their responsibilities, which could in turn affect HHS's ability to use the program as a way to meet its objective of enhancing Americans' access to health care.

In addition, the lack of numeric enrollment targets for HHS to evaluate its performance with respect to the open enrollment period hampers the agency's ability to make informed decisions about its resources. HHS reported achieving a successful consumer experience for the 2018 open enrollment period based on enhancing its performance in areas that had been problematic in the past. However, the agency's evaluation of its performance did not include aspects of the consumer experience that it identified in 2017 as key, and for which stakeholders reported problems in 2018. As a result, its assessment of its performance in enhancing the consumer experience was likely incomplete. Absent a more complete assessment, HHS may not have the information it needs to fully understand the consumer experience.

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## Recommendations for Executive Action

We are making the following three recommendations to HHS:

- The Secretary of HHS should ensure that the approach and data it uses for determining navigator award amounts accurately and appropriately reflect navigator organization performance, for example, by
  1. providing clear guidance to navigator organizations on performance goals and other information they must report to HHS that will affect their future awards,
  2. ensuring that the fields used to capture the information are functioning properly, and

- 
3. assessing the effect of its current approach to funding navigator organizations to ensure that it is consistent with the agency's objectives. (Recommendation 1)
- The Secretary of HHS should establish numeric enrollment targets for healthcare.gov, to ensure it can monitor its performance with respect to its objectives. (Recommendation 2)
  - Should the agency continue to focus on enhancing the consumer experience as a goal for the program, the Secretary of HHS should assess other aspects of the consumer experience, such as those it previously identified as key, to ensure it has quality information to achieve its goal. (Recommendation 3)

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its comments, reproduced in appendix VI, HHS concurred with two of our three recommendations. HHS also provided technical comments, which we incorporated as appropriate.

HHS concurred with our recommendation that it ensure that the approach and data it uses for determining navigator awards accurately and appropriately reflect navigator organization performance. In its comments on our draft report, HHS stated that it had notified navigator organizations that their funding would be linked to the organizations' self-identified performance goals and their ability to meet those goals. On July 10, 2018, HHS issued its 2019 funding opportunity announcement for the navigator program, which required those applying for the award to set performance goals, including for the number of consumers assisted with enrollment and re-enrollment in exchange plans, and also states that failure to meet such goals may negatively impact a recipient's application for future funding.<sup>70</sup> In its comments, HHS also noted that it is in the process of updating the healthcare.gov website so that individual applications can hold the identification numbers of multiple entities, such as navigators, agents or brokers, and will work to ensure that the awards align with agency objectives.

HHS also concurred with our recommendation that the agency assess other aspects of the consumer experience, such as those it previously

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<sup>70</sup>Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Cooperative Agreement to Support Navigators in Federally-facilitated Exchanges, *Notice of Funding Opportunity* (July 10, 2018).

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identified as key, to ensure it has quality information to achieve its goal. HHS noted that it had assessed the consumer experience based on the availability of the two largest channels supporting exchange operations, and also noted that it will consider focusing on other aspects of the consumer experience as needed.

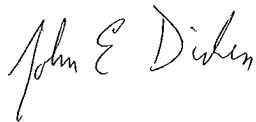
HHS did not concur with our recommendation that the agency establish numeric enrollment targets for healthcare.gov, to ensure that it can monitor its performance with respect to its objectives. Specifically, HHS noted that there are numerous external factors that can affect a consumer's decision to enroll in exchange coverage that are outside of the control of HHS, including the state of the economy and employment rates. HHS stated that it does not believe that enrollment targets are relevant to assess the performance of a successful open enrollment period related to the consumer experience. Instead, it believes a more informative performance metric would be to measure whether everyone who utilized healthcare.gov, who qualified for coverage, and who desired to purchase coverage, was able to make a plan selection.

We continue to believe that the development of numeric enrollment targets is important for effective monitoring of the program and management of its resources. Without establishing numeric enrollment targets for upcoming open enrollment periods, HHS's ability to evaluate its performance and make informed decisions about how it should deploy its resources is limited. We also believe that these targets could help the agency meet its program objectives of stabilizing the market and of increasing the mix of younger and healthier consumers purchasing plans through the individual market. Furthermore, HHS has previously demonstrated the ability to develop meaningful enrollment targets using available data. For example, in prior years, HHS developed numeric enrollment targets based on a range of factors, including the number of exchange enrollees, number of uninsured individuals, and changes in access to employer-sponsored insurance, Medicaid, and other public sources of coverage. In addition, the agency set numeric enrollment targets for regional markets that took these and other factors into account. Once these targets were established, HHS officials were able to use them to monitor progress throughout the open enrollment period and revise its efforts as needed.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS. In addition, the report will be 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](mailto: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 VII.



John E. Dicken  
Director, Health Care

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*List of Requesters*

The Honorable Bob Casey  
Ranking Member  
Special Committee on Aging  
United States Senate

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

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

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

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# Appendix I: GAO List of Factors That May Have Affected 2018 Healthcare.gov Enrollment

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We identified a list of factors that may have affected 2018 healthcare.gov enrollment based on a review of Department of Health and Human Services information, interviews with health policy experts, and review of recent publications by these experts related to 2018 exchange enrollment.

Factors related to the open enrollment period:

- Open enrollment conducted during a shorter 6-week open enrollment period.
- Consumer awareness of this year's open enrollment deadline.

Factors related to plan availability and plan choice:

- Plan affordability for consumers ineligible for financial assistance.
- Plan affordability for consumers eligible for financial assistance.
- Consumers' perceptions of plan affordability.
- Availability of exchange-based plan choices.
- Availability of off-exchange plan choices.
- Consumer reaction to plan choices.

Factors related to outreach and education:

- Reductions in federal funding allocated to outreach and education, and lack of television and other types of advertising.
- Top Administration and agency officials' messaging about the health insurance exchanges and open enrollment.
- National and local media reporting on the exchanges and open enrollment.
- Local outreach and education events conducted by federally funded navigator organizations.
- Outreach and education efforts and/or advertising by some states, issuers, advocacy groups, community organizations, and agents and brokers.

Factors related to enrollment assistance and tools:

- Availability of one-on-one enrollment assistance from federally funded navigator organizations.

- Availability of one-on-one enrollment assistance from agents and brokers.
- Updates to the content and function of the healthcare.gov website.
- Availability of the healthcare.gov website during the open enrollment period.
- Availability of assistance through the call center during the open enrollment period.

Other factors:

- Consumer understanding of the Patient Protection and Affordable Care Act and its status.
- Automatic re-enrollment occurred on the last day of the open enrollment period.



# Appendix II: Information about Stakeholders Interviewed

Stakeholder type	Number of organizations interviewed	Stakeholder information
Navigator organizations <sup>a</sup>	4	Navigator organizations were selected to reflect a range in: (1) amount of 2018 award from the Department of Health and Human Services (HHS); (2) change in HHS award amount from 2017; (3) region; and (4) target population.
State insurance departments	6	Insurance departments in six states that use the federally facilitated exchanges were selected to reflect a range with respect to: (1) 2018 healthcare.gov enrollment outcomes; (2) strategies used for calculating 2018 premiums to compensate for the loss of federal cost-sharing reduction payments; (3) changes in 2018 navigator organization award amounts; and (4) the number of issuers offering 2018 exchange coverage in the state.
Issuers <sup>b</sup>	3	Three issuers were selected who offered 2018 plans on healthcare.gov exchanges; two of which sold exchange plans in multiple states.
Research and consumer advocacy organizations	5	Five research and consumer advocacy organizations were selected to provide a range of perspectives with respect to the law and issues related to exchange outreach and enrollment.
Professional trade associations	3	Three professional trade associations were selected to collectively represent the perspectives of regulators, issuers, and consumer assisters.
State-based exchanges <sup>c</sup>	2	Two state-based exchanges were selected based on the length of their open enrollment periods—one had one of the shortest open enrollment periods and the other had one of the longest open enrollment periods for 2018.

Source: GAO. | GAO-18-565

<sup>a</sup>Navigator organizations, among other things, carry out public education activities and help consumers enroll in a health insurance plan offered through the exchange. HHS awards financial assistance to navigator organizations that provide these services in states using the federally facilitated exchange.

<sup>b</sup>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.

<sup>c</sup>State-based exchanges are able to set their own budget and strategy for promoting exchange enrollment and set the length of their open enrollment periods.

# Appendix III: Characteristics of Healthcare.gov Enrollees, 2017 and 2018

	2017		2018	
	Number	Portion	Number	Portion
<b>Metal tier of selected plan<sup>a</sup></b>				
Bronze	1,977,938	21	2,452,538	28
Silver	6,827,122	74	5,688,110	65
Gold	303,989	3	528,087	6
Platinum	21,773	0	16,731	0
Catastrophic	70,983	1	58,176	1
<b>Financial assistance<sup>b</sup></b>				
Advance Premium Tax Credit	7,765,735	84	7,447,615	85
Cost-Sharing Reduction	5,513,078	60	4,758,871	54
<b>Enrollment type<sup>c</sup></b>				
New enrollees	3,013,107	33	2,460,431	28
Returning enrollees	6,188,698	67	6,283,211	72
<b>Age</b>				
Under 18	878,958	10	803,649	9
18-25	976,976	11	893,718	10
26-34	1,496,794	16	1,389,848	16
35-44	1,448,931	16	1,378,238	16
45-54	1,833,195	20	1,773,445	20
55 or older	2,516,951	27	2,504,744	29
<b>Gender</b>				
Male	4,204,498	46	3,979,972	46
Female	4,997,307	54	4,763,670	54
<b>Race</b>				
Asian	600,311	7	629,935	7
African-American	660,655	7	598,440	7
White	4,446,285	48	4,309,822	49
Multiracial and Other	145,823	2	364,366	4
Unknown	3,348,731	36	2,841,079	32
<b>Ethnicity</b>				
Latino	956,516	10	1,033,699	12
Not Latino	8,245,289	90	7,709,943	88
<b>Household location<sup>d</sup></b>				
Rural	1,636,711	18	1,573,716	18
Not Rural	7,565,094	82	7,169,926	82

**Appendix III: Characteristics of Healthcare.gov  
Enrollees, 2017 and 2018**

	2017		2018	
	Number	Portion	Number	Portion
<b>Household income</b>				
100 to 250 percent of the federal poverty level	6,571,317	71	6,142,502	70
251 to 400 percent of the federal poverty level	1,539,081	17	1,614,363	18
Other or not reported	1,091,407	12	986,777	11
<b>Total enrollment</b>	<b>9,201,805</b>		<b>8,743,642</b>	

Source: GAO analysis of Department of Health and Human Services data. | GAO-18-565

Notes: Percentages may not sum to 100 due to rounding. Healthcare.gov enrollment reflects that for 39 states, including 34 federally facilitated exchanges and 5 state-based exchanges, as of January 31, 2017 (for 2017), and December 23, 2017 (for 2018).

<sup>a</sup>Metal tiers reflect plans' actuarial values—a measure of the relative generosity of the plan's benefits that is expressed as a percentage of the covered medical expenses to be paid, on average; as the actuarial value increases, consumer cost-sharing decreases. The actuarial values of the metal tiers are: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). Catastrophic plans have low monthly premiums and high deductibles and are only available to certain individuals who are under 30 years old or meet other criteria; premium tax credits are not available for the purchase of these plans.

<sup>b</sup>Depending on their incomes, enrollees may be eligible for financial assistance to help offset their monthly premium amount through a premium tax credit—which is often paid to an enrollees' issuer in advance in the form of an advance premium tax credit—or cost-sharing reduction, which helps to lower the amount that eligible individuals pay for deductibles, coinsurance, and co-payments.

<sup>c</sup>For 2017, new enrollees included those who enrolled during the open enrollment period and did not have coverage through a healthcare.gov plan as of November 1, 2016—the first day of the 2017 open enrollment period. For 2018, new enrollees included those who enrolled during the open enrollment period and did not have coverage through a healthcare.gov plan as of December 31, 2017.

<sup>d</sup>Household locations are classified based on the Federal Office of Rural Health Policy's definition of rural and non-rural areas, which incorporates rural-urban commuting area codes.

# Appendix IV: Selected Stakeholder Views of Factors Likely Affecting 2018 Enrollment in Healthcare.gov Plans

We identified a list of factors that may have affected 2018 healthcare.gov enrollment based on a review of Department of Health and Human Services (HHS) information, interviews with health policy experts, and review of recent publications by these experts related to 2018 exchange enrollment. Using this list, we conducted structured interviews with officials from 23 stakeholder organizations to gather their viewpoints as to whether and how these or other factors affected 2018 health insurance exchange enrollment. Organizations interviewed were selected to reflect a wide range of perspectives and included HHS-funded navigator organizations that provide in-person consumer enrollment assistance, issuers, state insurance departments, professional trade organizations, research and advocacy organizations, and state-based exchanges. Table 2 displays a range in stakeholder views about the impact of these factors.

**Table 2: Selected Stakeholder Views of Factors Likely Affecting 2018 Enrollment in Healthcare.gov Plans**

Factors	Selected reasons stakeholders cited as to why the factor		
	Negatively affected enrollment	Had no effect on enrollment	Positively affected enrollment
Plan affordability	<ul style="list-style-type: none"> <li>Consumers ineligible for financial assistance faced substantially higher premiums for 2018, in part due to the elimination of federal cost-sharing reduction payments to issuers.</li> </ul>	<ul style="list-style-type: none"> <li>Some consumers ineligible for financial assistance were used to annual premium increases and continued their enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>The widespread availability of free bronze and low-cost gold plans attracted consumers eligible for financial assistance to enroll.</li> </ul>
Availability of plan choices	<ul style="list-style-type: none"> <li>In some areas, fewer issuers offered plans than in the past, resulting in the loss of provider networks or higher premiums.</li> </ul>	<ul style="list-style-type: none"> <li>In some areas, there was little change in the plans available to consumers.</li> </ul>	<ul style="list-style-type: none"> <li>Among those eligible for financial assistance, exchange plans provided the most affordable option for obtaining coverage.</li> </ul>
Consumer confusion about the Patient Protection and Affordable Care Act (PPACA) and its status	<ul style="list-style-type: none"> <li>Consumers were unaware of whether (1) PPACA had been repealed, (2) coverage was available through the exchanges, (3) the individual mandate was still in effect, and (4) the elimination of federal cost-sharing reduction payments would result in the loss of their cost-sharing reductions.</li> </ul>	<ul style="list-style-type: none"> <li>In prior years, consumers have enrolled in coverage without having understood PPACA.</li> </ul>	<ul style="list-style-type: none"> <li>N/A.</li> </ul>

**Appendix IV: Selected Stakeholder Views of  
Factors Likely Affecting 2018 Enrollment in  
Healthcare.gov Plans**

Factors	Selected reasons stakeholders cited as to why the factor		
	Negatively affected enrollment	Had no effect on enrollment	Positively affected enrollment
Administration messaging	<ul style="list-style-type: none"> <li>Administration officials negatively portrayed the exchanges which spurred uncertainty and confusion among consumers about whether the exchanges and individual mandate existed.</li> </ul>	<ul style="list-style-type: none"> <li>The general public does not hear or listen to Administration messaging.</li> </ul>	<ul style="list-style-type: none"> <li>N/A.</li> </ul>
National and local media reporting	<ul style="list-style-type: none"> <li>Some media reporting negatively portrayed the exchanges, and other reporting provided inaccurate information, both of which furthered consumer confusion.</li> </ul>	<ul style="list-style-type: none"> <li>Media reporting had no effect on enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>An increase in media coverage of the exchanges during 2017, likely due to a political debate about the future of the exchanges, as well as coverage of the open enrollment season, likely aided consumer awareness of the open enrollment period.</li> </ul>
Reduction in federal advertising and consumer outreach	<ul style="list-style-type: none"> <li>Decreases in advertising and outreach tend to result in lower consumer awareness and enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>Consumers who are interested in enrolling will enroll regardless of advertising.</li> </ul>	<ul style="list-style-type: none"> <li>N/A.</li> </ul>
Outreach and education efforts conducted by states, issuers, advocacy groups, and community groups	<ul style="list-style-type: none"> <li>A decrease in outreach efforts by some organizations likely detracted from enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>While some groups did more outreach than they had in the past, it was not enough to make a sizeable impact on enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>Additional efforts of issuers, agents and brokers, states, and community groups likely aided consumer awareness and enrollment.</li> </ul>
Enrollment conducted during a shorter 6-week open enrollment period and related consumer awareness of the new December 15 <sup>th</sup> deadline	<ul style="list-style-type: none"> <li>The shorter period provided less of an opportunity for enrollment and strained consumer enrollment assistance resources.</li> <li>Some consumers were not aware of the December 15, 2017, enrollment deadline.</li> </ul>	<ul style="list-style-type: none"> <li>During prior open enrollment periods, most consumers tended to enroll by December 15 in order to have coverage effective January 1.</li> </ul>	<ul style="list-style-type: none"> <li>The shorter period encouraged consumers to enroll earlier.</li> </ul>
Navigator organization outreach and assistance <sup>a</sup>	<ul style="list-style-type: none"> <li>Funding reductions limited the availability of some navigator organizations to conduct outreach and assist with enrollment, particularly in rural areas.</li> </ul>	<ul style="list-style-type: none"> <li>The work of navigator organizations has not resulted in notable impacts to enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>Outreach and one-on-one assistance, though less than for the 2017 open enrollment period due to funding decreases and a shortened enrollment period, aided enrollment, particularly for those with complex circumstances.</li> </ul>

**Appendix IV: Selected Stakeholder Views of  
Factors Likely Affecting 2018 Enrollment in  
Healthcare.gov Plans**

Factors	Selected reasons stakeholders cited as to why the factor		
	Negatively affected enrollment	Had no effect on enrollment	Positively affected enrollment
Assistance from agents and brokers <sup>b</sup>	<ul style="list-style-type: none"> <li>In some areas, agents and brokers are not as involved with the exchanges as in the past, due to lower commissions paid by some issuers.</li> </ul>	<ul style="list-style-type: none"> <li>There was no notable change in agent and broker availability this year.</li> </ul>	<ul style="list-style-type: none"> <li>Assistance from agents and brokers aided enrollment as they account for a large portion of enrollments each year.</li> </ul>
Healthcare.gov functionality and availability	<ul style="list-style-type: none"> <li>Enrollment could not occur through the website during scheduled maintenance windows, and any reduction in available time for enrollment harms enrollment results.</li> </ul>	<ul style="list-style-type: none"> <li>There were no significant changes to the website this year.</li> </ul>	<ul style="list-style-type: none"> <li>Website functioned well and was more available than it was in prior years.</li> </ul>
Call center availability	<ul style="list-style-type: none"> <li>N/A.</li> </ul>	<ul style="list-style-type: none"> <li>Call center assistance does not result in a notable impact on enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>Call center assistance was available and wait times were shorter than in prior years.</li> </ul>

Source: GAO analysis of stakeholder interviews. | GAO-18-565

Note: N/A = not available.

<sup>a</sup>Navigator organizations, among other things, carry out public education activities and help consumers enroll in a health insurance plan offered through the exchange. The Department of Health and Human Services awards financial assistance to navigator organizations that provide these services in states using the federally facilitated exchange.

<sup>b</sup>Agents and brokers are licensed by states to provide assistance to those seeking to enroll in a health plan, including those offered on the exchanges, and are generally paid by the issuers they represent or whose plans they sell.

# Appendix V: HHS Paid Advertising Expenditures for 2017 and 2018 Open Enrollment Periods

Expenditures related to paid advertising	Amount of HHS expenditures per open enrollment period	
	2017	2018
Television	\$26,600,000	\$0
Radio	900,000	0
Search <sup>a</sup>	17,600,000	2,700,000
Desktop display <sup>b</sup>	1,300,000	175,000
Mobile display <sup>c</sup>	3,200,000	800,000
Digital video <sup>d</sup>	4,700,000	1,225,000
Social media	3,100,000	1,000,000
Digital audio <sup>e</sup>	800,000	0
Outdoor <sup>f</sup>	700,000	0
Spanish language <sup>g</sup>	7,900,000	750,000
Phone, email, and text	6,500,000	2,000,000
Mail	8,200,000	0
Strategic consulting, production, labor, and analytics	7,750,000	1,350,000
Other <sup>h</sup>	10,750,000	0
<b>Total</b>	<b>\$100,000,000</b>	<b>\$10,000,000</b>

Source: GAO analysis of Department of Health and Human Services (HHS) data. | GAO-18-565

Notes:

<sup>a</sup>For search advertising, Internet search engines displayed a link to healthcare.gov when individuals used relevant search terms.

<sup>b</sup>For desktop display advertising, certain websites displayed advertisements for healthcare.gov if consumers had visited healthcare.gov recently.

<sup>c</sup>For mobile display advertising, certain websites and mobile applications that certain consumers visited on their mobile phones displayed advertisements for healthcare.gov if the consumers had visited healthcare.gov on their mobile phones recently.

<sup>d</sup>For digital video advertising, HHS created and posted video advertisements for healthcare.gov targeted to young potential enrollees on video-sharing websites.

<sup>e</sup>For digital audio advertising, HHS ran audio advertisements for healthcare.gov on Internet streaming services.

<sup>f</sup>For outdoor advertising, HHS used billboards and other outdoor means of advertising healthcare.gov.

<sup>g</sup>Spanish language advertising involved performing radio, search, and other types of advertising in Spanish.

<sup>h</sup>The expenditures in this category included, among others, paid advertising for the Small Business Health Options Program and expenses that were recovered after HHS suspended some of its paid advertising during the final week of the 2017 open enrollment period.

# Appendix VI: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

JUL 09 2018

John Dicken  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance*" (GAO-18-565).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in blue ink, appearing to read "Matthew D. Bassett for".

Matthew D. Bassett  
Assistant Secretary for Legislation

Attachment



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH INSURANCE EXCHANGES: HHS SHOULD ENHANCE ITS MANAGEMENT OF OPEN ENROLLMENT PERFORMANCE (GAO-18-565)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on the HHS Federally-facilitated Exchange (Exchange). HHS is committed to providing a cost-effective and successful experience for consumers who utilize HealthCare.gov. HHS takes seriously its responsibilities to protect taxpayer funds and provide a positive experience to consumers, brokers and other individuals and entities who access the Exchange.

HHS' primary goal for the 2018 open enrollment period was to ensure that consumers had a seamless enrollment experience. HHS utilized tools such as direct outreach and advertising, as well as partnerships with brokers and navigators to accomplish this goal. Data from the Federal Health Insurance Exchange call center shows that the consumer satisfaction rate reached an all-time high – averaging 90 percent. In addition, HHS worked to make HealthCare.gov available with minimum downtime or interruption throughout the entire enrollment period, using only 22.5 hours of regular maintenance time, which was less than the hours used during any previous enrollment period.

In addition to ensuring high consumer satisfaction, HHS also made the 2018 open enrollment period the most cost-effective enrollment period to date, as approximately 8.7 million consumers selected or were automatically re-enrolled in an Exchange plan in the 39 states using HealthCare.gov. These figures show that while HHS spent less on outreach and advertising, enrollment stayed essentially the same as the previous year. HHS accomplished this by funding direct outreach and advertising tactics that were proven to be highly productive in addition to adjusting the open enrollment marketing budget to align with advertising spending for Medicare enrollment. These outreach methodologies have proven the most effective in reaching existing and new enrollees. Outreach was targeted based on specific demographic and geographic data. This approach was not only based on previous evaluation of past Exchange outreach efforts, but is also consistent with promotional spending for Medicare enrollment.

To further promote accountability and cost-effectiveness, Navigator grantees received funding based on their performance in meeting their enrollment goals during the previous year. Historically, Navigators have accounted for less than 1 percent of enrollments, regardless of higher funding levels. For the 2018 enrollment period, Navigator grantees were asked to assist consumers with plan selections, and to focus outreach efforts to inform consumers of the revised open enrollment dates for 2018 coverage.

GAO's recommendations and HHS' responses are below.

**Recommendation 1**

The Secretary of HHS should ensure that the approach and data it uses for determining Navigator award amounts accurately and appropriately reflect Navigator performance, for example by:

- Providing clear guidance to Navigators on performance goals and other information they must report to HHS that will affect their future awards
- Ensuring that the fields used to capture the information are functioning properly, and
- Assessing the effect of its current approach to funding Navigators to ensure that it is consistent with agency's objectives

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH INSURANCE EXCHANGES: HHS SHOULD ENHANCE ITS MANAGEMENT OF OPEN ENROLLMENT PERFORMANCE (GAO-18-565)**

**HHS Response**

HHS concurs with this recommendation.

HHS has provided guidance to Navigators that their grant funding will be explicitly tied to their self-identified goals and their ability to meet those goals. For the upcoming open enrollment period, HHS is in the process of modifying Healthcare.gov to hold identification numbers from multiple entities allowing both Navigator and Agent/Broker identification numbers on the same application. HHS is currently soliciting applications for the next Navigator program multi-year grant cycle and will work to ensure that the awards align with agency objectives.

**Recommendation 2**

The Secretary of HHS should establish numeric enrollment targets for Healthcare.gov, to ensure it can monitor its performance with respect to its objectives.

**HHS Response**

HHS does not concur with this recommendation.

There are numerous external factors that can affect a consumer's decision to enroll that are outside the control of HHS, such as the state of the economy, issuer rates, employment rates, and the number of people who effectuate their coverage. These are factors that are wholly unrelated to the performance of Healthcare.gov. HHS believes a more informative performance metric is whether everyone who utilized Healthcare.gov, who qualified for coverage, and who desired to purchase coverage, was able to make a plan selection. HHS does not believe that numeric enrollment targets are relevant to assess the performance of objectives related to a successful open enrollment period for the Exchange by enhancing the consumer experience.

**Recommendation 3**

Should the agency continue to focus on enhancing the consumer experience as a goal for the program, the Secretary of HHS should assess other aspects of the consumer experience, such as those it previously identified as key, to ensure it has quality information to achieve its goal.

**HHS Response**

HHS concurs with this recommendation.

HHS assessed the consumer experience through the availability of the two largest customer channels supporting exchange operations – the call center and Healthcare.gov – as well as customer satisfaction surveys. HHS believes these metrics represent a comprehensive assessment of the consumer experience. HHS is always looking for ways to improve the consumer experience and will consider focusing on other aspects of the consumer experience as needed.

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# Appendix VII: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken, (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; Patricia Roy, Analyst-in-Charge; Priyanka Sethi Bansal; Giao N. Nguyen; and Fatima Sharif made key contributions to this report. Also contributing were Muriel Brown, Laurie Pachter, and Emily Wilson.

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