July 2, 2018

The Exchanges Trends Report

This report presents an analysis of the current condition of the operational and programmatic aspects of the Exchanges. In 2018, the Centers for Medicare and Medicaid Services (CMS) instituted a number of policies that promote program integrity, stabilize the individual market, and foster continuous coverage. Specifically, CMS made investments to improve the Exchange Call Center, support the role of agents and brokers in Federal platform Exchanges, and instituted a verification process to decrease fraudulent coverage requests through a Special Enrollment Period (SEP). CMS conducted extensive surveys to gauge how these changes were implemented, how they impacted consumers, and how the Exchanges can continue to be improved. Similar to the 2017 report[1], this report also examines enrollment as it relates to affordability, financial assistance, and plan choice. The analysis shows that while CMS achieved the highest stakeholder satisfaction to date, lack of affordability continues to be a driving factor that determines whether currently uninsured consumers choose to buy health coverage through the Exchanges using the Federal platform.

Key Highlights

- Data from the call center shows that the consumer satisfaction rate remained at an all-time high – averaging 90 percent – throughout the entire Open Enrollment period. This is up from 85 percent last year.
- 63 percent of uninsured consumers who have visited Federal platform Exchanges in the past year indicate they didn't purchase a health plan through the Federal platform because the health insurance premium was too expensive, which is up from 52 percent from the end of last year's Open Enrollment Period.
- Despite significant improvements to the agent and broker program, lack of competition in the Exchanges and limited availability of commissions continues to pose challenges to the agent and broker community.
- For plan year 2017, approximately 90 percent of SEP applicants who made a plan selection and were required to submit documents to complete enrollment were able to satisfy SEP verification requirements and begin coverage.

[1] https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf

I. Consumer Experience: CMS has made significant improvements to the consumer experience on Federal platform Exchanges but the uninsured continue to be priced out of the individual market

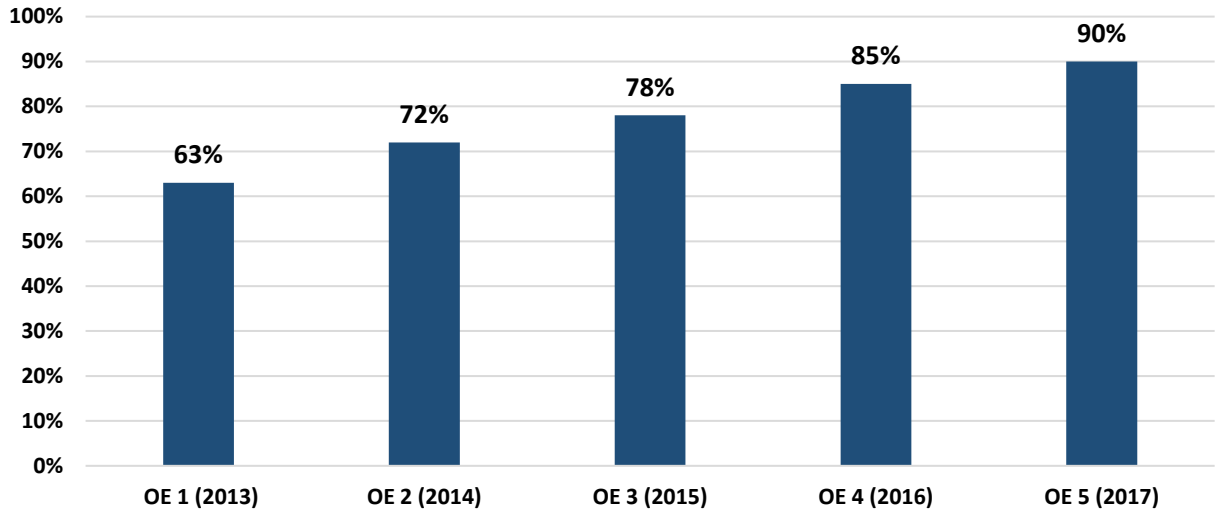
Key Highlights

- The call center consumer satisfaction rate hit and remained at an all-time high – averaging 90 percent.
- Lack of affordability of plans is the top reason uninsured participants decided not to purchase insurance.
- Consumers cited increased access to other types of coverage as a reason for ending Marketplace coverage (about 70-75 percent). This includes employer-sponsored health coverage, Medicare, Medicaid or other coverage.

CMS continues to make significant progress in improving consumer experience in enrolling in a health insurance plan, which we continuously measure through consumer surveys and other consumer engagement activities. The information collected through our consumer engagement activities indicate the fifth Open Enrollment period for plan year 2018 through the Exchanges was the smoothest and most efficient enrollment experience for consumers to date. Consumer research conducted throughout Open Enrollment shows the highest rates of consumer satisfaction at the call center of any Open Enrollment period. While improvements to the technical and operational aspects of the enrollment process resulted in increased consumer satisfaction, rising premiums were a top consumer concern. A majority (63 percent) of uninsured participants surveyed after Open Enrollment who visited Federal platform Exchanges but did not purchase health insurance said they chose not to buy health insurance because the premium was too expensive. CMS will continue to make improvements to provide a seamless enrollment process. However more fundamental changes are needed to lower premiums and provide more flexible, affordable coverage.

Federal platform Exchange call center data show that the consumer satisfaction rate remained at an all-time high, averaging 90 percent throughout the entire Open Enrollment period. This is up from 85 percent last year. Similar to previous years, there was a surge in the number of consumers contacting the call center and visiting Federal platform Exchanges during the final days of Open Enrollment. Despite the increase in volume, both Federal platform Exchanges and the call center operated optimally and, for the first time, waiting rooms were not deployed online during the final days of Open Enrollment. This provided consumers with exceptional site availability when the greatest number of consumers were making plan selections.

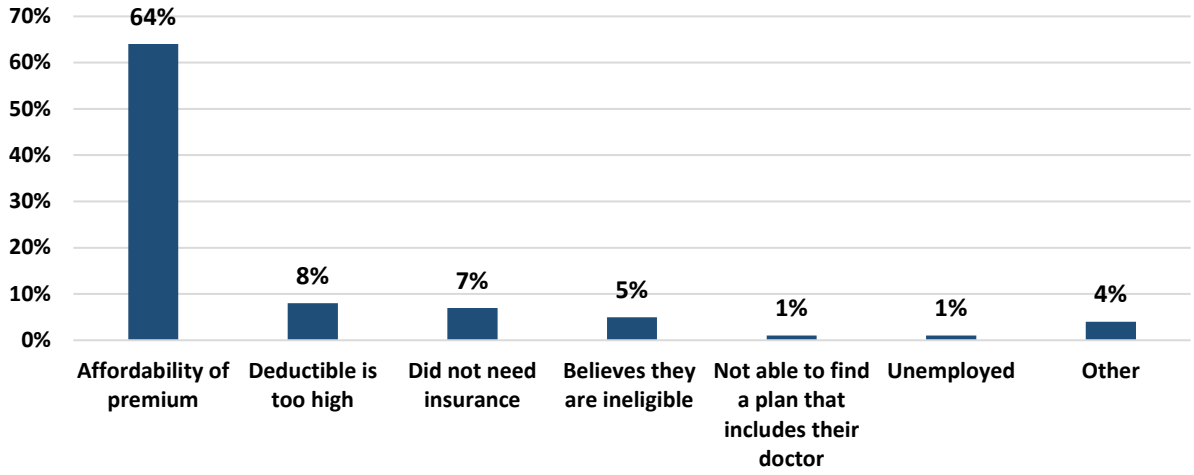
Figure 1. Customer Satisfaction with Exchange Call Center



Source: CMS data

Lack of affordability of plans is the top reason uninsured participants decided not to purchase insurance. Of uninsured consumers visiting Federal platform Exchanges in the past year, 63 percent of those who did not purchase a plan indicated high premiums as the primary motivator for the decision not to purchase, which is up from 52 percent from the end of last year's Open Enrollment Period. Among all currently uninsured participants, the primary reason provided for not having health insurance continues to be that they are unable to afford it because it is too expensive (54 percent). Similar to previous results, about 15 percent of uninsured consumers indicated the reason they do not have insurance is because they are unemployed. Based on Open Enrollment survey activities, we asked uninsured individuals whether they had Exchange health plans in the past, and 21 percent of the uninsured sampled indicated that they had a prior Exchange plan.

Figure 2. Reasons Uninsured Participants Did Not Purchase Insurance



Source: CMS Data

Reasons for ending coverage remains consistent from previous years. We continue to see consistently through ongoing survey activities at the call center that gaining other coverage is most often the reason cited by consumers for ending Exchange coverage (about 70-75 percent). This includes employer-sponsored health coverage, Medicare, Medicaid or other coverage, with employer-sponsored health coverage being the most common coverage type. Additionally a smaller percentage of consumers cite unaffordability (around 15 percent) or dissatisfaction (just under 10 percent) as their reason for calling to end their coverage.

II. Agent and Broker Experience: Agents and Brokers Continue to Play a Key Role, But Face Ongoing Challenges

Key Highlights:

- For plan year 2018, 49,100 agents and brokers registered with Federal platform Exchanges, supporting 42 percent of overall enrollments.
- The cost breakdown for registration/training, technical assistance, and oversight is $2.40 per enrollee.
- The biggest concerns for agents and brokers are lack of competition in the individual market and availability of commissions from insurance carriers.
- To date, CMS has implemented 93 percent of recommendations from our agent and broker partners.

CMS has made a concerted effort to leverage the capabilities of the private sector by expanding the role of health insurance agents and brokers in the field. CMS recognizes agents and brokers as important partners in the field that guide consumers through the complexities of the health care market. Agents and brokers who participate in Federal platform Exchanges provide essential, local support to consumers by educating them about coverage options. They help consumers throughout the enrollment process from requesting an eligibility determination to selecting a plan. Agents and brokers also provide ongoing support to consumers, such as resolving enrollment and coverage issues and updating application information due to life changes. For plan year 2018, 49,100 agents and brokers registered with the Federal platform before the end of Open Enrollment on December 15, 2017. These agents and brokers supported 3,660,668 health plan enrollments during the Open Enrollment period (42 percent of overall enrollment in Federal platform Exchanges). By helping connect consumers with health coverage, agents and brokers play a critical role in ensuring a seamless consumer experience without the additional expense of their being paid with taxpayer dollars.

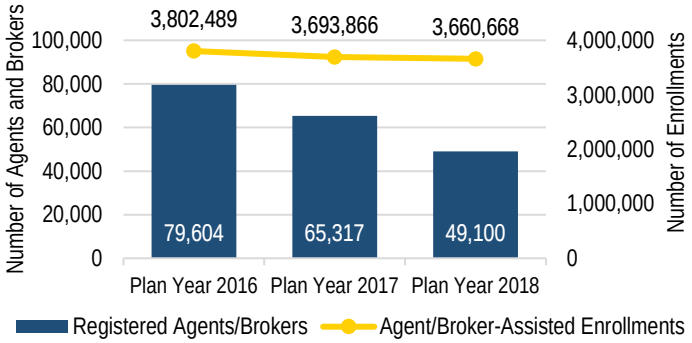
CMS support to agents and brokers has received strong, positive feedback. CMS supports agents and brokers by providing annual training and registration, ongoing guidance and outreach resources, dedicated help desks to respond to agent and broker inquiries, and tools to help them connect with consumers. In May 2017, CMS asked agents and brokers participating on the Federal platform for feedback on its agent and broker program. CMS analyzed this feedback and identified 70 actionable recommendations to improve program operations, increase agent and broker satisfaction, and respond to their feedback from consumers on ways to improve the enrollment process. Given the high volume of enrollees that use agents and brokers compared to other consumer assistance programs, CMS also uses this feedback as a tool to verify if we have deployed sufficient resources and education tools for agents and brokers to continue improving

the consumer experience. As of May 2018, CMS has implemented 93 percent of these 2017 recommendations.

After the plan year 2018 Open Enrollment period, CMS asked agents and brokers for additional feedback to track progress against key metrics and previously implemented recommendations. Respondents expressed increased satisfaction across the board, including with the effectiveness of communications, training, registration, and consumer-facing tools like Find Local Help. Of nearly 5,000 respondents, 85 percent reported that they are likely to participate in the Exchanges for plan year 2019.

The number of agents and brokers participating in the Exchanges is decreasing, but their impact on consumer enrollments remains strong. From plan year 2016 to plan year 2018, the number of agents and brokers registered on the Federal platform dropped by nearly 40 percent, yet the number of enrollments they assisted decreased by less than 4 percent. (Figure 3). During the plan year 2018 Open Enrollment period, agents and brokers assisted 42 percent of consumer medical plan enrollments, a from 40 percent from previous years. Issuer exits, rising coverage costs for consumers, and lack of compensation from issuers have contributed to decreasing agent and broker participation. However, as these statistics show, consumers who seek assistance are increasingly turning to agents and brokers, and those agents and brokers who continue to participate in Federal platform Exchanges have demonstrated their ability to effectively meet this need.

Figure 3. Agent and Broker Activity during Open Enrollment Periods

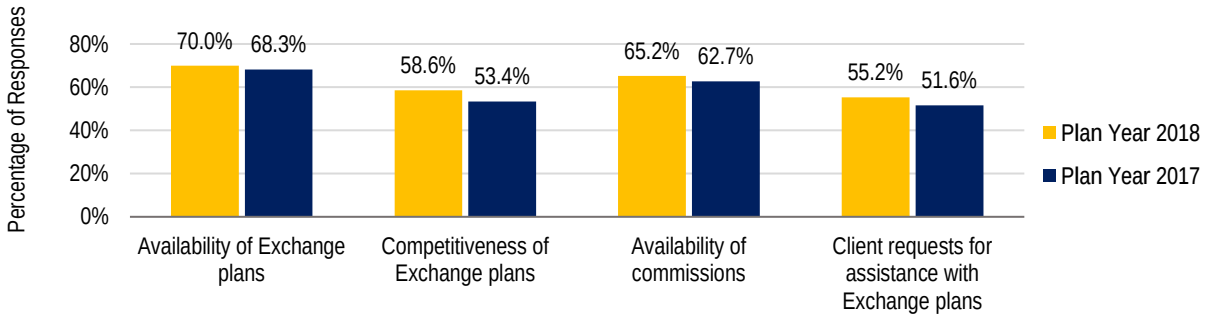


In the face of a declining agent and broker population, CMS has successfully worked to retain, engage, and empower agents and brokers as valued private sector partners. For example, for plan year 2018, CMS introduced "Help On Demand," a new tool that connects consumers seeking assistance on Federal platform Exchanges with local, Federal platform-registered, state-licensed agents who can provide immediate assistance with applications and enrollments. Approximately 5,300 agents and brokers participated in Help On Demand for plan year 2018. When asked for feedback on their experience, 62 percent of these agents and brokers felt that Help On Demand expanded their business and 89 percent reported that they intend to participate again for plan year 2019. CMS' Circle of Champions program recognizes high-performing agents and brokers who actively enroll 20 or more consumers in Exchange coverage each year. For plan year 2018, nearly 50 percent of all Federal platform-registered actively participating agents and brokers were recognized in the Circle of Champions.

Despite significant improvements to the agent and broker program, lack of competition in the Exchanges and limited availability of commissions continue to pose challenges to the agent and broker community. Based on agent and broker feedback, the limited availability and competitiveness of Exchange plans and lack of commissions were the strongest drivers behind

their decision not to participate on the Federal platform in the future (Figure 4). Many agents and brokers have stopped actively assisting Exchange consumers because of reduced commissions and their inability to contract with carriers. Many receive no compensation at all for their enrollment assistance. Without a viable compensation structure for agents and brokers, it may be difficult for CMS to improve or stabilize agent and broker retention and achieve significant enrollment gains – leaving consumers with diminished access to insurance specialists willing to help them in their local communities.

Figure 4. Factors that Influence Agent and Broker Decisions about Future Exchange Participation



Source: CMS Data

In their feedback from May 2018, agents and brokers also cited ongoing frustrations with the online application and enrollment process, the burden of establishing annual authorizations over the phone and the shortage of agent/broker-focused customer service resources with the ability to resolve complex consumer issues.

CMS is taking steps to respond to Agent and Broker feedback for plan year 2019. Similar to last year, CMS is working to implement 49 new recommendations to address agent and broker feedback received this year. Notably, for plan year 2019, the Exchanges are continuing to make improvements to the online experience of Federal platform. Over time, these refinements will address many of the ongoing frustrations identified by agents and brokers by streamlining the online application and simplifying the process to enroll consumers in coverage through the Exchanges. CMS is also launching new Exchange capabilities with its private sector direct enrollment (DE) partners, including both issuers and web-brokers. Agents and brokers working with CMS-approved DE partners will have access to enrollment and client management tools and services that are not available to them on Federal platform. These new capabilities will make it easier for agents and brokers to assist their clients with eligibility determinations, plan selections, and year-round account management for Exchange coverage, while reducing the need to use the Federal platform or the Exchange Call Center.

Building on progress to date, CMS will continue its efforts to improve the agent and broker experience and provide new tools and programs that better support these key stakeholders. CMS will work collaboratively with its agent and broker partners to find additional solutions to critical challenges impacting the agent and broker community and improve their ability to assist consumers with Exchange plans and coverage.

III. Special Enrollment Period Experience: Eligible consumers continue to be able to use Special Enrollment Periods (SEPs) when appropriate, while new approaches to verification approaches promote program integrity and market stability.

Key Highlights

- Approximately 1.1 million consumers applied for coverage after the 2017 Open Enrollment Period (OEP) and made a plan selection through a special enrollment period (SEP), while approximately 9.2 million individuals had an active plan selection at the close of the 2017 OEP.
- The majority of consumers who received a SEP outside of the OEP, approximately 60 percent, received a SEP for loss of minimum essential coverage (MEC).
- For plan year 2017, approximately 90 percent of applications with a plan selection and a SEP requiring document verification satisfied the SEP verification requirements.
- For plan year 2017, the average age of consumers who enrolled with a SEP was 34 years old, which is seven years younger than the average age of consumer who enrolled during OEP.

Background on special enrollment periods (SEPs). In the Exchanges, most consumers select a plan during the OEP. Consumers who experience one of six types of life events[2] can also select a plan during a SEP. For states using the Federal platform for plan year 2017, 1.1 million individuals applied for coverage after OEP and made a plan selection through a SEP, while approximately 9.2 million individuals had an active plan selection at the close of the 2017 OEP.[3]

SEPs are a longstanding feature of employer-sponsored health coverage, ensuring that people who lose coverage during the year (for example, through non-voluntary loss of minimum essential coverage provided through an employer), or who experience other qualifying life events (for example, marriage or the birth or adoption of a child) have the opportunity to enroll in new coverage or make changes to their existing coverage. While the annual OEP allows uninsured individuals to enroll in new coverage, SEPs are intended, in part, to promote continuous enrollment in health coverage during the plan year by only allowing those who were previously enrolled in coverage to obtain new coverage or make changes to existing coverage without experiencing a gap in coverage.

CMS implements SEP policy changes in 2017 to improve risk pool and stabilize the individual market. As outlined in the 2017 Market Stabilization Rule[4], CMS has taken steps to limit the use of the exceptional circumstances SEP to ensure access to coverage for individuals and families while further promoting program integrity, stabilizing the individual market, and encouraging continuous coverage throughout the year. Starting in June 2017, CMS began requiring verification of exceptional circumstance SEPs where practicable and issued guidance

[2] https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf
[3] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html
[4] https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization

to clarify situations in which certain groups of consumers may be eligible for an exceptional circumstance SEP – for example, individuals impacted by Hurricanes Harvey, Irma and Maria.

Prior to June 2017, SEPs were approved through self-attestation of the occurrence of a qualifying life event and the meeting of other eligibility criteria on the Exchange application. However, as the Government Accountability Office noted, relying on self-attestation without verifying documents submitted to support a SEP triggering event could allow applicants to obtain subsidized coverage for which they would otherwise not qualify.[5] In addition, verification of SEPs prevents people who elected not to enroll in coverage during the annual OEP from instead enrolling in coverage through a SEP that they would not otherwise qualify for during the coverage year, minimizing the risk of adverse selection from individuals who wait to enroll until they are sick. Abuse of SEPs can create a sicker risk pool, leading to higher rates for consumers and less availability of coverage.

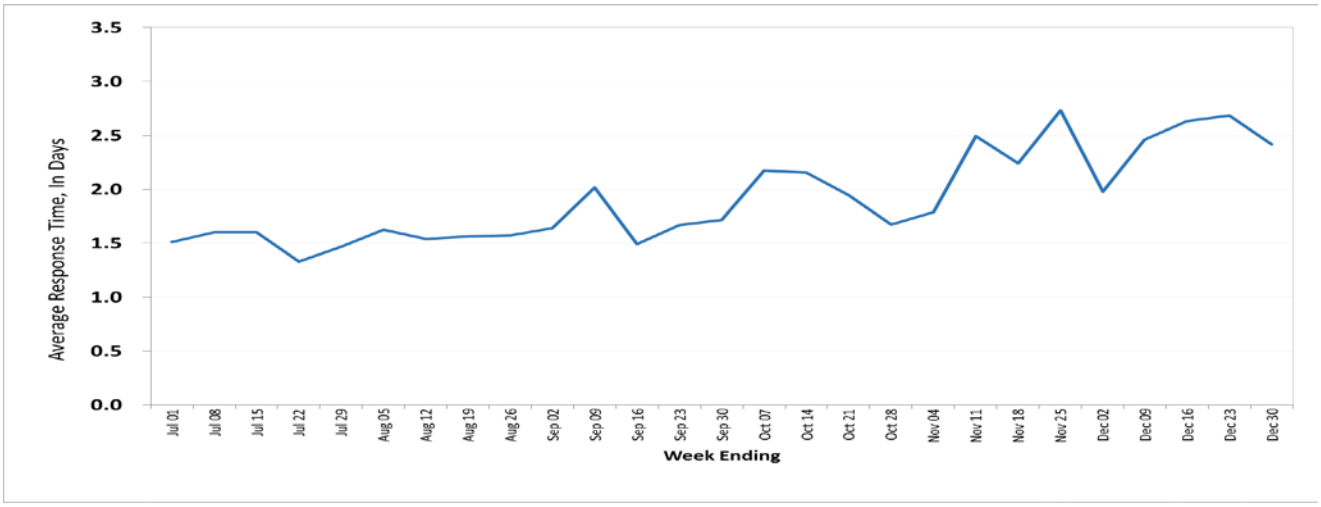
CMS is committed to making sure that SEPs are available to those who are eligible for them, and equally committed to avoiding any misuse or abuse of SEPs. The new SEP policies are intended to promote continuous enrollment in coverage and protect the risk pool from adverse selection that may have a destabilizing impact on the market for existing enrollees. Beginning in June 2017 new applicants in states using the Federal platform are now required to verify their eligibility for certain SEPs before coverage can start. Starting at the end of June 2017, this pre-enrollment verification applied to consumers attesting to a loss of MEC or a permanent move. In August 2017, CMS expanded pre-enrollment verification to include new applicants attesting to having been denied by a Medicaid agency, or adding or becoming a dependent through marriage, adoption, foster care, or court order.

The Federal platform uses existing data sources whenever possible to electronically verify eligibility of these SEP-types before generating the applicant's eligibility determination. If electronic verification is not possible, consumers are asked to submit documents that establish their eligibility for a special enrollment period within 30 days. In cases of electronic verification, the applicant is simply notified that he or she is eligible to enroll in coverage through a SEP and not asked to provide additional documentation.

CMS met the needs of consumers seeking SEPs while continuing efforts to stabilize the individual market. With the 2017 policy changes, CMS instituted a rigorous verification process to ensure eligible consumers were able to complete the enrollment process and begin coverage. When a consumer's SEP cannot be electronically verified, CMS provides significant consumer outreach and support – including e-mails, mailed notices, and phone calls – to help ensure that eligible individuals are able to satisfy SEP verification requirements and complete their enrollment. As shown in Figure 5, CMS averages a response time of one-to-three days to review consumer submitted documents. Once SEP verification began, for plan year 2017, the vast majority (over 90 percent) of SEP applicants who made a plan selection and were required to submit documents to complete enrollment were able to successfully verify their eligibility for the SEP.

[5] November 2016, Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO–17– 78, U.S. Government Accountability Office.

Figure 5. Exchanges Response Time to SEP Verification Document, 2017



Source: CMS Data

Plan year 2017 SEP enrollment data. These figures include plan selections associated with an application submitted after the OEP and for consumers without coverage at the time of application submission. Plan selections made by enrollees who enrolled during the OEP are not reflected here.

Table 1: Distribution of SEP Reasons among 2017 Consumers in states using the Federal platform with a Plan Selection after Annual OEP

SEP Reason	Count of Plan Selections	% of Plan Selections
Minimum Essential Coverage (MEC) loss	670,183	60%
Medicaid/Children's Health Insurance Program denial	272,831	24%
Moved to a new service area	56,214	5%
Change in household size (marriage, newborn, adoption)	47,453	4%
Other SEP types	39,673	4%
Exceptional Circumstance	22,225	2%
Change in eligibility for financial assistance for Exchange coverage	15,717	1%
Total	1,124,326	100%

Source: CMS Data

The volume of exceptional circumstances SEPs granted by CMS declined by 56 percent between the 2016 and 2017 plan years. The majority of consumers applying outside OEP, approximately 60 percent, received an SEP for loss of minimum essential coverage (MEC). Thus consumers generally are using SEPs to enroll in Exchange coverage after losing other health insurance, like coverage from their job. Another 24 percent of SEP plan selections were made by consumers who initially applied for coverage during OEP, but needed to wait to receive an eligibility determination from their state Medicaid agency before they could be determined eligible for Exchange coverage and/or financial assistance. Finally, smaller numbers of consumers enrolled for other reasons, such as birth, adoption, marriage, permanent move, or other circumstances.

The average age of SEP enrollee is notably younger than the average age of OEP enrollee. The average age of SEP enrollees in 2017 was 34 years old, while the average age of OEP enrollee was 41. The majority of SEP enrollees in 2017 were under the age of 35.

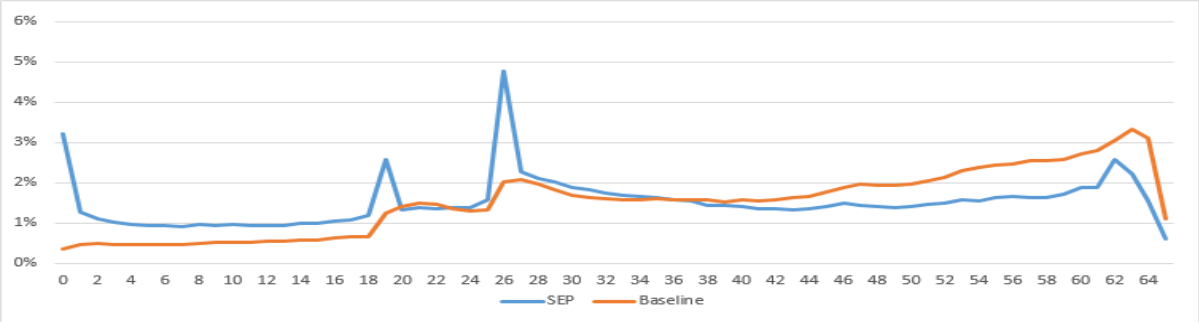
Table 2: SEP Plan selections versus OEP plan selections by age, in states using the Federal platform

Age Group	Open Enrollment Plan Selections		SEP Plan Selections	
	#	%	#	%
17 and under	878,958	10%	225,267	20%
18-34	2,473,770	27%	360,243	32%
35-54	3,332,126	36%	326,153	29%
55+	2,516,951	27%	212,660	19%
Total	9,201,805	*100%*	1,124,326	*100%*

Source: CMS Data

Figure 6 illustrates a spike in SEP usage at the time of birth, up to age 19 (which is the maximum age that a child can qualify for CHIP coverage), and at age 26 (which is generally the maximum age that a child can be covered under their parent's health insurance plan under federal regulations).

Figure 6. Percentage of enrollees in states using the Federal platform by age at the time of enrollment



Each consumer is counted only once. Only consumers who were on applications submitted after OE, did not have coverage at time of submission, received an SEP, and made a plan selection are included.

Source: CMS Data

Conclusion

CMS has taken new steps to avoid misuse of SEPs and stabilize the risk pool, while also ensuring that SEPs remain available to eligible consumers. CMS has demonstrated effectiveness in its consumer outreach and document review processes relating to new SEP verification requirements. 1.1 million consumers made a plan selection through a SEP in PY2017, and approximately 90 percent of applications with a plan selection and a SEP requiring verification through document submission satisfied the SEP verification requirements. SEP enrollees are younger than those who selected plans during the Open Enrollment period, suggesting Exchanges using the Federal platform continue to provide valuable continuity in coverage for younger consumers as they experience qualifying life changes.