BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

August 4, 2014

The Honorable Tim Murphy
Chairman
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

Thank you for your June 27, 2014 letter. The information you have requested is attached.

Sincerely,

Alissa Fox

Alissa Fox
Senior Vice President
Blue Cross Blue Shield Association

The Honorable Marsha Blackburn

1. How many insurance policies has Blue Cross Blue Shield sold in Tennessee via the federal exchange? How many did the Tennessee Blue sell in 2012 and 2013?

As of today, we have sold 120,121 policies through the Federally Facilitated Marketplace (FFM). This includes any policies that have since cancelled/terminated after being effectuated.

According to our internal Direct Markets Sales Report, the number of policies sold in our Individual under 65 line of business for the two prior years is as follows:

- 2013 – 20,644
- 2012 – 18,143

2. What difficulties has Blue Cross Blue Shield experienced with the implementation of the health care law? What difficulties do you expect in the future?

Like other health plans, we have experienced issues with accuracy and completeness of data transmitted from the Federally Facilitated Marketplace. We have worked closely with federal officials and consumers to make sure we have the correct information in enrolling new members through the Marketplace. The Administration continues to finalize the "back-end" functionality of HealthCare.gov, and health plans are doing a significant amount of the work manually. Our number one goal is for our customers to have a good experience, and Blue Plans will continue to work around the clock to help consumers navigate the new system.

The Honorable Michael C. Burgess

1. While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.

a. Have any significant improvements been made to these components?

There is still significant amount of work needed on the back-end and Plans are doing a much of the work manually. This includes:

- Payment systems: the 820 electronic payment transaction still must be put in place, so in the interim, Plans are submitting excel spreadsheets;
- Enrollment reconciliation; and

- Processing life event changes such as the birth of a child or getting married.

b. How will these continued problems affect plan participation and premiums for 2015?

Our number one goal is for consumers to have a good experience and get enrolled in the Plan of their choice. We will continue to work to ensure consumers have access to affordable, high quality health coverage.

2. 834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.

a. Has this been your experience?

b. What is your estimation of the failure rate?

c. Has the failure rate improved over time and by how much?

d. What problems has this caused for your companies, your enrollees, and contracted providers?

BCBSA is not an issuer and does not have a system to capture 834 transmissions; therefore we do not have the information necessary to answer these questions

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

a. Do you have an estimation of the number of duplicate enrollments in your system?

No, this is not something we track.

b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

We do not know the methodology the administration used in calculating enrollment numbers.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is

terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

a. I f enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

BCBSA is not a health insurance company and does not pay provider claims. However, we note that while the CMS Exchange Final Rule issued in 2012 allows issuers to pend claims during the second and third month of the ACA's 3 month grace period, issuers are required under the regulation to retroactively terminate coverage to the end of the first month of the grace period if an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums. Specifically, Section 156.270(g) says "the QHP issuer must terminate the enrollee's coverage on the effective date described in Section 155.430(d)(4)," which is "the last day of the first month of the 3-month grace period."

b. If you do not pay the claims, who will make providers whole?

In general, state grace period requirements preceded enactment of the ACA's 3-month grace period. Under these requirements, issuers, providers and consumers follow established policies which typically address instances when individuals incur claims from a provider and that individual is not a covered member in a health plan. BCBSA is not a health insurance company and does not pay provider claims.

c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

No, BCBSA is not a health insurance company and does not write health insurance plans or policies.

d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

No, we do not have the data to answer this question.

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

a. Do you know how many enrollees are currently covered but behind on paying their premiums?

No, BCBSA does not collect this data.

b. The law says that you must provide this information to HHS. Are you doing so?

No, BCBSA is not a health insurance company, therefore does not collect this data.

c. What is the process for communicating with providers when enrollees enter a grace period?

As Plans implement requirements for the ACA's three month grace period, Plans continue to use the communication methods that work best with providers in their local markets. BCBSA does not collect the methodologies Plans use to communicate with their providers.

6. Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.

a. Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?

b. Please describe the process if there is a process in place.

c. If there is a process, have any miscalculated payments been reconciled?

d. I f miscalculated payments have been reconciled, how many have been processed?

e. Please provide an estimation for the administrative cost of these miscalculations if possible.

f. How might the miscalculation of payments affect plans for next year in terms of participation or premiums?

Based on the recent HHS Office of the Inspector General report on inconsistencies, while over one million new enrollees are currently in the inconsistency period, it does not "necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP or is receiving financial assistance through insurance affordability programs inappropriately." Since the beginning of the year, issuers have received monthly payments for subsidized enrollees from CMS through an interim payment process based on

aggregated payment data. CMS has indicated that later this year, issuers and CMS will transition to a member-level payment process and reconcile all payments previously made under the interim process. CMS has not published specific details of the transition or reconciliation process, and thus BCBSA does not have any estimates of the administrative costs associated with the transition or reconciliation.

The Honorable Pete Olson

1. In your experience, has CMS built the operation function to pay health plans participating in the Federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?

Since the beginning of the year, issuers have received monthly payments for subsidized enrollees from CMS through an interim payment process based on aggregated payment data. CMS has indicated that later this year, issuers and CMS will transition to a member-level payment process and reconcile all payments previously made under the interim process. CMS has not published specific details of the transition or reconciliation process.

2. Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?

For the Federally Facilitated Marketplace that is run primarily by the federal government (which includes 32 states including the Partnership states), the federal government user fee will apply to insurers in order to help the funding of the marketplace. Currently, user fees charged by the federal government cover the majority of costs related to the continued operation of federally facilitated marketplace. For example in FY 2015, user fees will fund 66% of the operating cost for the federal marketplace. http://cms.hhs.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf (see page 31) These user fees will support activities such as the enrollment, consumer outreach, education and assistance activities that health plans currently pay themselves. Marketplaces are required by the ACA to be self-sustaining on January 1, 2015.

3. Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?

BCBSA is not an issuer and does not have a system to capture 834 transmissions; therefore we do not have the information necessary to answer these questions

The Honorable Morgan Griffith

1. One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians- particularly specialists- are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice- give up their specialist or pay the high cost sharing required for out-of-network physicians.

a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

We would advise encouraging consumers to make use of the searchable, web-based provider directory tools that health plans make available to determine which specialists participate. If the consumer has trouble finding or using the tool, he or she should call the Plan's customer service line.

b. What kind of information about provider networks will be available to help them choose a plan?

As independent companies, Blue Plans all provide searchable web-based directories to help consumers find providers by name or by type within a geographic region (e.g., all in-network cardiologists by county, or within a 5 mile radius of a zip code). The directories typically include information about the provider's accessibility and quality. For hospitals, the directory will likely indicate whether it's a Blue Distinction Facility (a hospital recognized on the basis of extensive criteria developed with medical specialty societies – such as the track record for procedure results -- as having proven expertise in delivering that specialty care), and overall patient reviews on a five-star scale; for physicians, the directory will likely show not only basics such as board certification, accepting new patients, uses e-prescribing, wheelchair accessible, but also various quality metrics such as the "Blue Recognition Program" (primary care physicians who are active in a national, regional, and/or local quality improvement and/or recognition program), clinical quality measures (e.g., breast cancer screening rates), and patient ratings.

c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

Every year Blue Plans update and enhance the quality information available about in-network providers, and strive to maintain the accuracy of their directories. As accredited organizations, qualified health plans must meet specific standards. For example, NCQA requires that plans' physician and hospital directories contain the most current information, that plans test the directory for understanding and member ease of use, and make the directory available in other formats (e.g., printed, by telephone) for those who do not want to or cannot search a web-based directory.