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August 29, 2014

BY E-MAIL AND U.S. MAIL

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

RE: Questions for the Record dated June 27, 2014

Dear Chairman Upton:

This letter comprises the second response of WellPoint, Inc. ("WellPoint" or the "Company") to the June 27, 2014 letter containing questions for the record regarding the testimony of Dennis Matheis before the Subcommittee on Oversight and Investigations on May 7, 2014 at the hearing titled "PPACA Enrollment and the Insurance Industry."

The Company has provided the enclosed responses, with information as of the date of the hearing unless otherwise noted, to the Member requests relating to the Committee's hearing and investigation regarding the Federally-Facilitated Marketplace (FFM). We will continue to confer with Committee staff regarding the remaining requests.

While the Company is responding to your inquiry voluntarily and is providing the enclosed information, the submission of this information does not waive, nor is it intended to waive, any rights, privileges, or immunities of WellPoint with respect to this matter, including any applicable attorney-client, work product, or other privilege or immunity. WellPoint expressly reserves all applicable privileges and immunities to which it is entitled under applicable law.

* * *

If you have any questions regarding this letter, please contact me at (202) 637-5493.

Sincerely,

[redacted]

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cc: The Honorable Diana DeGette
Ranking Member, Subcommittee on Oversight and Investigation

Questions for the Record for Dennis Matheis for WellPoint

Attachment 1- Additional Questions for the Record

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?**

   While CMS is working to improve a number of issues that are impacting the functionality of Healthcare.gov, back end functionality is still being addressed. Two of the most pressing functionality issues are the 834 and 820 processes.

   834 Enrollment Data Reconciliation
   A permanent, automated 834 maintenance solution should be implemented to prevent divergence between issuer and FFM enrollment data. Doing so will improve data accuracy and allow plans to reallocate resources from continued manual processes to other critical functions.

   820 APTC/Premium Reconciliation
   CMS has yet to implement an automated 820 transaction system that issuers can use to reconcile the Advanced Premium Tax Credits (APTC) and Cost Sharing Reduction (CSR) subsidies. Until CMS implements an accurate 820 system, issuers and the FFM will continue to use a manual monthly Interim Payment Process. Any manual process is subject to higher error rates and will result in difficulties reconciling APTC and CSR payments at a subscriber/member level.

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

   In preparing 2015 premium rates, WellPoint subsidiaries have not taken into account the administrative costs incurred in working through issues arising from back-end systems whose functionality continues to be addressed. At some point if the challenges posed by the back-end systems are not addressed, WellPoint subsidiaries will need to evaluate whether increased administrative expenses will affect premium rates. The Company has reached no conclusion on what impact, if any, the back-end issues will have on plan participation in 2015.

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?

Response to 2(a)-(d):

WellPoint is unable to determine a failure or error rate for the 834 transmissions received from the Exchange. CMS – and not WellPoint – would have complete information on errors involving 834 transmissions. WellPoint can confirm, however, that it has experienced significant problems with the 834 transmission process. These errors in the 834 transmission process have created challenges for WellPoint staff and enrollees which WellPoint is working with CMS to overcome. For example, some customer abrasion issues have occurred when the customer believes they have submitted an application through the Exchange, but WellPoint has not received or is unable to process the application. In addition, delays in coverage for applicants can result when WellPoint must go back to the Exchange to request a corrected application file or where desired changes to a customer's plan were delayed due to 834 functionality issues. These and other issues with implementing the designed 834 functionality have resulted in increased manual work for WellPoint.

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?

For the states in which WellPoint subsidiaries participate on the FFM (Georgia, Indiana, Maine, Missouri, New Hampshire, Ohio, Virginia, and Wisconsin), the FFM at times sent additional records as New Enrollments for the same applicants. Through the date of the hearing, these additional enrollments accounted for approximately 11% on average of the total submissions and terminations, not including voided enrollments requested by the Exchange.

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

WellPoint is not privy to the process and the data the Administration uses to calculate enrollment totals. WellPoint has no information on whether the Administration has or has not included duplicate enrollments in the enrollment totals it has reported. WellPoint has not included the additional records in its net 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. If 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?

In cases where the member has not paid their premium after the first month for on-exchange subsidy eligible products, the Company takes the following steps, as defined by regulations implementing the legislation:

- Process claims for services received during the first month. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer must: Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period").
- Pend claims for services received during the second and third months of the grace period, until the full premium is received. Providers will receive a notification on their remittance indicating that the claim cannot be paid until the premium is received, and informing providers of the possibility of denied claims if the premium is not received by the end of the three month grace period. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer . . . may pend claims for services rendered to the enrollee in the second and third months of the grace period"); 45 C.F.R. §156.270(d)(3) ("Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period").
- After the third month, if the member's premium is not received, the member's health plan will be terminated as provided in 45 C.F.R. §156.270(g), and the claims for services received during the second and third month will be denied. The member will be responsible for payment of services received during this time (up to charges). *See* 45 C.F.R. § 155.430 (d)(4) ("In the case of a termination [after the expiration of the 3-month grace period], the last day of coverage will be 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?

The terms and conditions of the contract between WellPoint subsidiaries and providers apply to care rendered to "Covered Persons." When a policy or plan is terminated due to non-payment, the individual is no longer a Covered Person and the provider may bill the individual directly for services rendered.

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

The Company does not have a recoupment process for claims incurred during the second and third months of the grace period for on-exchange subsidy eligible products because, as described above in response to question 4(a), provider claims for services during the second and third month of the grade period are not paid unless the member pays their premiums for those months. As required by 45 C.F.R. §156.270(d)(1), the Company processes claims incurred during the first month of the grace period regardless of whether the subscriber ultimately pays the premium for the first month of the grace period.

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.

WellPoint is unable to readily recreate historical data regarding the number of plans in the second or third month of the grace period as of the date of the Committee's hearing.

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?

WellPoint is unable to readily recreate historical data regarding the number of plans in the second or third month of the grace period as of the date of the Committee's hearing.

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

HHS has asked that this information be shared through the 834 reconciliation process and the Company will do so when that process is in place.

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

WellPoint subsidiaries value their relationships with contracted providers and strive to keep providers fully informed. Information regarding the grace period is available to providers through various channels. For example, state-specific information about health insurance exchanges and the grace period is available on the Provider Portal for each state in which WellPoint subsidiaries participate in the FFM: http://www.anthem.com/home-providers.html (The user must choose a state before going to that state's provider homepage and select "Health Insurance Exchange information".)

In particular, before providing a service to a subscriber of a WellPoint subsidiary, providers can electronically check whether the subscriber is in a grace period through the online eligibility and benefits process on the Provider Portal. The Company understands that many providers do check the patient's eligibility prior to the patient's visit as part of the provider's established office procedures. If a provider submits a claim for a subscriber in the grace period, the provider will receive a notification on their remittance indicating that the claim

cannot be paid until the premium is received, and informing providers of the possibility of denied claims if the premium is not received by the end of the three month grace period. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer . . . may pend claims for services rendered to the enrollee in the second and third months of the grace period"); 45 C.F.R. §156.270(d)(3) ("Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period").

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. **If miscalculated payments have been reconciled, how many have been processed?**

Response to 6(a)-(d):

The subsidy process begins when a consumer provides his or her income, family size, and additional demographic information during the application process through the Exchange. Based on the information provided by the consumer, the Exchange calculates the applicant's premium and any applicable APTC or CSR. The Exchange then provides the applicant's premium rate, APTC, and CSR to the Company in the 834 membership records. For CSR subsidized products, a per member per month ("pmpm") rate was filed and approved for each product. The Company works with the Exchange to ensure that the CSR amount is accurate for any given product, as the CSR subsidy rates applicable to a particular product contained in the 834 membership records are incorrect in some cases. The Company uses the APTC amount provided by the Exchange and any applicable CSR amount to reduce the premium amount to be collected from the subscriber. For states in which the Company participates in the FFM, the Company then submits the APTC information it received from the Exchange and the applicable CSR amount to CMS on a monthly basis and Treasury sends those funds to the Company through an Interim Payment Process ("IPP"). To date, the Company has not taken steps to attempt to reconcile the interim payments received from Treasury as CMS has described the payments as interim in nature and not final payments that would permit the Company to close its open receivables.

Because the Company does not possess information on the consumer's income level or other demographic circumstances, the Company is unable to validate whether the APTC calculations it receives from the Exchange are accurate for any particular member. The

Company relies solely on the information received from CMS for all eligibility and subsidy related information. The Company does not communicate directly with our customers regarding income levels or other demographic circumstances. If any change occurs to a consumer's income or demographic information, it is the responsibility of the consumer to notify the Exchange, and for the Exchange to send the Company an updated 834 file with revised premium payment calculations. The Company understands that the IRS may recoup improper APTC or CSR payments from the consumer if a consumer submitted inaccurate income information to the Exchange.

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

WellPoint has not calculated the total administrative costs attributable to updated 834 files received from Exchanges or the Interim Payment Process with CMS.

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

In preparing 2015 premium rates, WellPoint subsidiaries have not taken into account the administrative costs attributable to issues regarding membership reconciliation or premium subsidies. At some point if the challenges posed by these processes are not addressed, WellPoint subsidiaries will need to evaluate whether increased administrative expenses will affect premium rates. The Company has reached no conclusion on what impact, if any, these issues will have on plan participation in 2015.

7. If a provider calls your company for information on the health care law, what resources or information is your company able to provide?

WellPoint subsidiaries value the participation of providers in their networks and strive to keep providers fully informed about the ACA. If a provider contacts a WellPoint subsidiary with questions regarding the ACA, the Company can provide information regarding what the law allows related to a member's benefits and can answer general questions regarding the ACA. The Company can also direct the provider to external sources for additional information, such as a government website regarding the plan in which the member enrolled or to professional forums.

In addition, as described in the response to 5(c), providers can access the Company's provider portal for their state. The provider portal contains a wealth of communications and updates regarding state-specific information on health care reform. Providers may also access member-specific benefit and premium grace period information through the provider portal using the member's identification number. Providers may enroll in WellPoint's Network eUPDATE which notifies recipients of new updates regarding Exchanges and the ACA. Providers also receive a bi-monthly newsletter notifying them of relevant updates, changes, and information, including regarding the ACA. Newsletters are mailed to providers and stored on the provider portal for future reference.

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?**

   CMS has implemented a basic, interim solution under which the Company is receiving payments for the Advanced Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR). WellPoint remains concerned about operational and functionality issues relating to the APTC and CSR. WellPoint is working with CMS through the interim solution and looks forward to a final, fully-functioning solution.

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?**

   WellPoint does not know how CMS accounts for the monies collected by the FFM user fee.

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?**

   Currently, the Company cannot definitively determine whether any 834 transactions remain outstanding until CMS fully reconciles all enrollment information with the issuers. CMS has not provided a definitive date on the completion of any enrollment reconciliation efforts nor has CMS provided a timeline as to when they will be able to have a fully functional 834 process with enrollment file maintenance capabilities.

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?**

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

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?

Response to 1(a)-(c).

The Company is committed to providing information to individuals considering enrolling in a plan. The Company provides at least three ways for an individual to determine which specialists are covered in an Exchange plan. First, individuals can visit www.anthem.com to search the online provider directory using the "Find a Doctor" link to determine if a doctor, hospital or other health care provider is a participating provider in the network for the particular plan. Second, they can call the applicable member services toll-free number. A member services representative will assist them in determining which specialists are participating providers. In Virginia, that number is 1-855-748-1810. Third, they can request a paper copy of a provider directory by calling the member services toll-free number or by sending a written request to the applicable plan. In Virginia, the request would go to Anthem Blue Cross and Blue Shield, P.O. Box 27401, Richmond, Virginia, 23286-8708. The Company continually assesses cost, quality and access and makes adjustments to its provider networks as needed to meet and exceed customer expectations, while optimizing the value of our members' health care expenditures. When a provider exits the network, member services representatives are available to assist subscribers in locating a participating provider to suit their needs.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

2. Provide any analysis conducted by your organization in 2012, 2013, or 2014 on the impact of the Patient Protection and Affordable Care Act on the premiums paid by consumers. Provide any other analysis conducted on deductibles, out of pocket costs, or the networks your company provides for plans sold on the Federally-Facilitated Marketplace or state exchanges.

On April 1, 2013 and April 9, 2013, the Company provided confidential documents from 2013 referring to the intersection of the ACA and premium rates to the Committee. Since that time, the Company has not conducted any analysis specifically addressing the impact of the Affordable Care Act on premiums paid by consumers, deductibles, out of pocket costs, or provider networks.

The Honorable Marsha Blackburn

1. **Submit to the Committee any analysis conducted by your organization or by another party for your organization on premiums for plans sold in the Federally-Facilitated Marketplace, state marketplaces, or off the federal or state exchanges in 2015.**

   WellPoint subsidiaries consider a variety of factors in setting rates. Some of those factors include our 75 years' experience in the market, extensive market research among consumers, medical trend, the health insurance tax, our experience with provider networks, assumptions about the effects of regulatory or legislative change, and assumptions about enrollment demographics. The internal rate development process can take between 3 and 6 months. Then the Company begins the process of working with state and federal regulators to finalize and obtain approval of the rates. The various types of insurance offered by WellPoint subsidiaries are subject to a variety of state and federal regulations and oversight. The processes and timelines associated with these vary substantially, including the submission and filing approval dates and the notification windows for consumers. The Company will fully comply with all of the applicable state and federal regulations.

   Elizabeth Hall, WellPoint's Vice President of Federal Affairs, participated in a June 27, 2014 panel for the Alliance for Health Reform where she discussed WellPoint's rate setting process. A video of the panel discussion is available at http://www.c-span.org/video/?320195-1/health-insurance-premiums. Additionally, the McKinsey Center for U.S. Health System Reform prepared an analysis of 2015 Individual Exchange Filings as of July 5, 2014, available at http://healthcare.mckinsey.com/2015-individual-exchange-filings-0.

The Honorable Morgan Griffith

1. **Provide a list of the states in which you will provide coverage on the federal or state exchange in 2015 and the date on which you will submit your 2015 premium rate filings. List the individuals in the federal or state government to which you will be submitting this information. Provide copies of those submissions to the Committee as they occur.**

   The Company has filed rates in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin with the intent to participate on the FFM or SBM in 2015. In addition, though Missouri does not require issuers to file rates, the Company intends to participate on the Missouri exchange. However, until the Company signs Qualified Health Plan contracts for 2015, the Company maintains discretion to make a final determination on whether to participate in the exchange.

   The Company's rate filings for exchange products are publicly available at the following links:

- Colorado: https://www.dora.state.co.us/pls/real/external_forms.serff_link# (click on "Click here to Search Health Insurance Filings" and search for Rocky Mountain Hospital & Medical Service, Inc. or HMO Colorado Inc.)

- Connecticut: http://www.catalog.state.ct.us/cid/portalApps/RateFilingCompanyDetails.aspx?sF=201403469&sN=60217&sC=Y&sT=H

- Indiana: http://www.in.gov/idoi/2869.htm (Anthem Insurance Companies, Inc.)

- Kentucky: http://insurance.ky.gov/RateFil/default.aspx (search for Anthem Health Plans of Kentucky)

- Maine: http://www.maine.gov/pfr/insurance/PPACA/HFAI.htm# (click on "Click Here to Search Public Filings" and search for Tracking Number AWLP-129567303)

- Nevada: http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Health_Rate_Review/2015-Rate-Filings.pdf

- New York: https://myportal.dfs.ny.gov/web/prior-approval/empirehc/empire-healthchoice-hmo-inc (Empire Health Choice Assurance, Inc., and Empire HealthChoice HMO, Inc.)

- Ohio: http://insurance.ohio.gov/Company/Pages/RecordsRequest.aspx (click on the link to access the HFAI. Then search for Community Insurance Company)

- Virginia: https://www.scc.virginia.gov/boi/SERFFInquiry/LHAccessPage.aspx (Click on Option #2 and search for HealthKeepers, Inc.)

The Company's rate filings for exchange products in California, Georgia, New Hampshire, and Wisconsin are not yet publicly available.