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July 11, 2014

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
2125 Rayburn Building
Washington, D.C. 20515

Dear Chairman Murphy:

I am writing in response to your letter of June 27, 2014 to provide answers to the questions that were submitted in writing by members of the subcommittee. My responses are included in the attached document.

Sincerely,

[redacted]

Mark C. Pratt

Attachment

cc: The Honorable Diana DeGette, Ranking Member

House Energy and Commerce Committee Hearing
on "PPACA Enrollment and the Insurance Industry"
May 7, 2014
Responses to Questions for the Record
by Mark Pratt, Senior Vice President, State Affairs, America's Health Insurance Plans

Questions From the Honorable Marsha Blackburn:

1. Mr. Pratt, has your organization done any analysis on whether consumers have been able to keep the doctors or medical providers they enjoyed prior to full implementation of the health care law? Please describe this analysis and submit it for the record.

   AHIP Response: AHIP recently commissioned a report from Milliman that examines how health plans use provider networks as a tool to keep costs down and to ensure that their members are receiving high quality care. The report describes how collaborative relationships between health plans and providers are leveraged to improve outcomes, as well as how provider networks are integrated into the health plan's benefit design. Moreover, the authors found that the use of high-value provider networks results in a 5 to 20 percent reduction of premiums. The full report is available at www.ahip.org/MillimanReportHPN2014/.

2. Has your organization done any analysis on the networks of providers offered by providers selling plans on the federal exchange? Please describe this analysis and submit it for the record.

   AHIP Response: Please see the response to Question 1 above.

Questions From 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?

      AHIP Response: While improvements have been made, much work remains to address several outstanding issues for full functionality of the federally-facilitated Marketplace (FFM). Work is now underway to reconcile enrollment data between health plans and the FFM – a key step to ensure consistency in the data between the FFM and the insurer that will be completed by early Fall. Plans continue to use manual and semi-automated processes to process special enrollment period enrollments through the temporary Change in Circumstance

(CIC) functionality as the FFM does not have the functionality to support a fully automated solution for insurers.

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

AHIP Response: We do not have sufficient information to make these types of projections.

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?

AHIP Response: As reported in my testimony, health plans have had to continue to perform manual processes and work-arounds that were necessitated by the problems that surfaced in the days and weeks following the October 1 launch and outstanding back-end issues. We are not in a position to provide information on specific failure rates.

b. What is your estimation of the failure rate?

AHIP Response: As we do not process enrollments directly, we are not in a position to comment on the specific failure rate of 834 files.

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

AHIP Response: As we do not process enrollments directly, we are unable to comment on the specific failure rate of 834 files. As I mentioned above, our plans have indicated there are improvements, but 834s in response to "Life events" still require manual processing to ensure accurate enrollment data and premium rates.

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

AHIP Response: Our member companies have been doing everything possible to ensure that back-end problems do not negatively impact health plan enrollees and contracted providers. However, we are aware of reports that 834 challenges can be error-prone and have negatively impacted some consumers.

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?

AHIP Response: As I indicated in my testimony, some consumers were advised to create a new account and enroll again. As a result, insurers have many duplicate enrollments in their system for which they never received any payment. In cases where an insurer has a new enrollment for a consumer who previously enrolled, they are not expecting that original policy to be effectuated – even though that data is still reported. However, as we do not process enrollments directly, we are not in a position to provide specific numbers of duplicate enrollments.

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

AHIP Response: We do not have any information in this area.

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?

AHIP Response: As mentioned in the question, health insurers have the option of only paying claims during the first month of the three-month grace period and pending claims during the second and third months. While our members are taking various approaches to implement the regulations, we do understand that most health plans are not paying claims during the entirety of the grace period. However, we do want to point out the requirements in the regulations and CMS guidance that health insurers are required to notify providers if their patients are currently in the grace period.

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

AHIP Response: We understand that upon receipt of outstanding premium payment, health plans will re-process any pended claims and reimburse the providers according to existing agreements. If the enrollee does not pay past due amounts, the provider may seek payment from the enrollee.

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

AHIP Response: For those health insurers that choose to only pay claims during the first month of the grace period, they will pay those claims using existing processes. During the second and third months, health plans have the option to pend claims, thus there is no reconciliation process necessary. As indicated above, upon receipt of premium payment, health plans will pre-process claims and pay using existing processes.

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.

AHIP Response: We do not have any such data.

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?

AHIP Response: No.

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

AHIP Response: Per existing CMS guidance, in the FFM, health plans were required to report this information to CMS as part of the required monthly enrollment reconciliation. However, this process has not yet been fully implemented. In addition, upon termination for non-payment of premium, health plans are required to send a termination 834 file to CMS which will indicate the reason for termination as "non-payment of premium."

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

AHIP Response: In accordance with 45 C.F.R. §156.270(d)(3) and CMS guidance, health insurers must notify providers that may be affected (meaning at least providers that submit claims for services rendered during the grace period) that an enrollee has lapsed in his or her payment of premiums. Issuers may utilize automated electronic processes to convey such notices. The notice must indicate there is a possibility that the issuer may deny payment of claims incurred during the second and third months of the grace period if the enrollee exhausts the grace period without paying the premiums in full. Insurers are required to notify all potentially affected providers as soon as is practicable when an enrollee enters 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?

      AHIP Response: On a monthly basis, health insurers are submitting enrollment and other data so that CMS may provide premium and cost-sharing subsidies to insurers. As part of this process, to provide updated information about regular enrollment changes, in addition to submitting information about the current month, health insurers are also making adjustments to past months (e.g., in the case of an incorrect enrollment or retroactive termination). We are not in a position to answer questions regarding the process to correct subsidy information for those individuals that have an "inconsistency" at this time.

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

      AHIP Response: Please see the response to Question 6(a.).

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

      AHIP Response: Please see the response to Question 6(a.).

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

      AHIP Response: We are not in a position to answer this question.

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

      AHIP Response: We are not in a position to answer this question.

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

      AHIP Response: We are not in a position to answer this question.

7. The ACA imposes an annual health insurance industry fee on carriers based on their proportion of market share.

   a. How is this fee affecting premiums currently and in the future?

AHIP Response: The ACA's tax on health insurance has increased the cost of coverage for consumers. An analysis by the actuarial firm Oliver Wyman estimated that the tax would increase premiums by 2.1 percent on average in 2014. Since the amount the tax is required to collect increases over time, premiums in 2023 are estimated to be, on average, 3.25 percent higher than they would be without the tax. The full analysis by Oliver Wyman is available at http://ahip.org/Issues/Documents/2011/Oliver-Wyman-Study--Estimated-Premium-Impacts-of-Annual-Fees-Assessed-on-Health-Insurance-Plans.aspx.

A subsequent analysis, also by Oliver Wyman, estimated the state-by-state impact of this tax, and is available at http://www.ahip.org/WymanState.

b. How is this fee affecting the decision to participate in the marketplace?

AHIP Response: Prior to the passage of the ACA, the Congressional Budget Office noted that the law's health insurance tax would be "largely passed through to consumers in the form of higher premiums for private coverage" (CBO Letter to Sen. Bayh, November 30, 2009). This tax, along with other taxes and fees associated with providing health insurance, increases the cost of coverage and makes coverage less affordable—particularly for small businesses and individuals purchasing coverage in the exchange.

Questions From 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?

AHIP Response: Yes, it is our understanding that the current manual processes are working. On a monthly basis, health insurers are submitting enrollment and other data so that CMS may provide premium and cost-sharing subsidies to insurers. As part of this process, if there was a change in enrollment, in addition to submitting information about the current month, health insurers are also making adjustments to past months (e.g., in the case of an incorrect enrollment or retroactive termination). We understand that CMS is in the process of building the fully automated process under which CMS would be providing this information directly to health insurers.

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?

AHIP Response: On a monthly basis, health insurers provide CMS with information related to enrollment and total premium which is used by CMS to calculate the FFM user

fee which are netted against subsidy payments to insurers. We are unaware of what happens once these fees are collected.

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?

AHIP Response: We are aware that for the individual market, the outstanding 834 transactions involve the 834 maintenance transaction which is used to report changes to demographic information (name, address, phone number) and report changes due to a special enrollment period (change in APTC, new plan, etc.). To support these types of changes without the full transaction, CMS has implemented the temporary Change in Circumstance (CIC) functionality which requires manual work by health insurers in order to process.

In addition, the process of submitting 834 files for enrollment reconciliation has not yet been implemented. An interim process will begin in July of 2014. We are unaware of the reason for the delay.

All 834 transactions related to the SHOP marketplace were deferred for 2014, and will be implemented for the 2015 plan year due to the delay of direct enrollment for the SHOP. In 2014 eligible employers can enroll directly with the health insurance plan.

Questions From 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?

   AHIP Response: Similar to last year, health plans are required to make their provider directories available to the Marketplace for publication online by providing the URL link to their network directory. CMS expects the URL link to direct consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. This is where all potential enrollees must go prior to enrollment to verify that their providers/specialists are part of the health plan's provider network before enrolling. This year, new guidance requires the URL provided to the Marketplace to link directly to the directory, such that consumers do not have to log on, enter a

policy number, or otherwise navigate the issuer's website before locating the directory.

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

AHIP Response: Regulations and CMS guidance require health plan provider directories to include location, contact information, specialty, medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. CMS encourages issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider.

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?

AHIP Response: In addition to the information above, we want to make clear that health plans work every day to ensure their provider directories are accurate and up-to-date. Thus it is very important for existing enrollees to review their health plan's provider directory during open enrollment and if their providers are not available, to make a change to another qualified health plan available in their area.