Akin Gump
STRAUSS HAUER & FELD LLP

STEVEN R. ROSS
+1202.887.4343/fax:+1202.887.4288
sross@akingump.com

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VIA HAND DELIVERY

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

Dear Chairman Murphy:

On behalf of Aetna Inc. ("Aetna" or "the Company"), we write in response to your June 27, 2014 letter (the "Letter") containing questions for the record and additional information requests made in connection with the Subcommittee's May 7, 2014 hearing, "PPACA Enrollment and the Insurance Industry." As discussed with Committee staff, today's submission addresses many of the questions posed by the Members of the Committee in your Letter. As additionally discussed with Committee staff, Aetna looks forward to meeting with staff to further discuss the balance of these questions. Please note that today's submission includes relevant information for all Aetna subsidiaries, including entities acquired through Aetna's acquisition of Coventry Health Care, Inc., and also for Innovation Health, a joint venture between Aetna and Inova Health System. As requested, and for the questions and subparts addressed in this submission, we have provided the information below in a format consistent with the Subcommittee's letter. Please note, as outlined below, that certain of the information provided in this submission is proprietary in nature, and we respectfully request that it be treated accordingly.

* * *

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?

Aetna's experience with the implementation of the Federally Facilitated Marketplace ("FFM") has been generally consistent with the well-publicized issues identified during the 2014 Open Enrollment. Some improvements have been made but more are needed. Aetna's experience is that the back-end, operational components of the FFM are not yet complete. Specifically, there are gaps in the FFM's Eligibility and Enrollment Module, and the FFM's Financial Management Module remains incomplete. For example, carriers send 834 termination transactions to the FFM, but it is unclear if they are processing them.

Ensuring that the FFM back-end is fully automated remains a key concern. Aetna continues to work with CMS, as appropriate, to address issues caused by these technical problems and to mitigate potential disruption to consumers.

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

Aetna uses several criteria to make decisions about participating in the public exchanges, including its ability to offer competitive products and services, projected medical cost experience with the population, and risks and uncertainties associated the regulatory and operational environment. For 2015, Aetna's public exchange footprint is likely to be similar to 2014 (to also include Georgia), but the Company's participation on any public exchange is not final until its filings—which include products, networks, and rates—are approved and Aetna chooses to sign the final participation agreement.

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?

Consistent with CMS guidance, Aetna reviews CMS-provided data to (1) remove duplicate records and (2) identify data inconsistencies on enrollment files for new members transmitted by the FFM. It is the Company's experience that 834 transmission issues which would cause an enrollment failure are typically resolved by working with CMS.

b. What is your estimation of the failure rate?

Please see Aetna's response to Question 2a above.

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

Please see Aetna's response to Question 2a above.

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

As noted above in the response to Question 1a, ensuring that the FFM back-end is fully automated remains a key concern for Aetna moving forward. The lack of back-end automation is among the well-publicized issues that led to the ACA's roll-out problems and many accounts of consumer frustration.

Aetna remains concerned that reconciliation of appropriate data between plans and CMS is not occurring properly and is leading to confusion between plans, beneficiaries, and CMS in certain instances. For example, when Aetna terminates coverage for lack of premium payment (after significant customer outreach and notification), it sends notice of termination records to CMS—but it is unclear if they are processing them. As a result, Aetna's experience is that CMS' records may indicate that those members continue to have coverage even though Aetna's records accurately reflect cancellation of that coverage due to non-payment. Therefore, those members may receive conflicting information about their coverage status if they contact both CMS and Aetna. Aetna has raised this issue with CMS and requested improvements to their system to address this problem.

Aetna does not retain federal subsidy payments for customers for the months in which their coverage has been terminated. As appropriate, Aetna will continue to offer feedback to CMS and Congress to help resolve operational issues and to mitigate the potential disruption to beneficiaries and employers.

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?

As described in Aetna's response to Question 2a above, consistent with CMS guidance, the Company reviews CMS-provided data to remove duplicate records before they are applied to its system. Aetna does not track the number of duplicate enrollments that have been sent by CMS and, therefore, does not have sufficient information to answer this question.

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

Aetna does not have sufficient information to answer this question.

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?

Consistent with applicable regulations and regulatory guidance, Aetna administers policies within the ninety-day "grace period" to minimize potential risks to providers. It is common practice for providers to verify the member's coverage before the member receives care. Providers typically reach out to Aetna in any of three standard ways—through a web-based eligibility confirmation tool, by phone call, or by a fax inquiry. If a provider asks through any of those channels about a member whose policy is in the grace period, Aetna will so inform the provider, who then has notice that the member may end up without coverage for services performed during the second and third months of the grace period.

Aetna updates the above data sources on a daily basis to ensure that providers have access to current information about the member's coverage status. Aetna makes payments for claims incurred during a grace period in accordance with regulatory guidance. The Company pays claims in line with the member's plan during the first month of the grace period and then holds, or "pends," claims that it receives during the second or third months of a grace period. Aetna does not pay those claims unless and until the subscriber becomes current on premium payments.

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

Please see Aetna's response to Question 4a above. In addition, it is important to underscore that providers have access to information—on a daily basis—that would allow them to determine if a patient has paid his or her premium.

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

No. Please see Aetna's response to Question 4a above.

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.

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

Yes. Aetna reports delinquency status data to HHS on a daily basis.

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

Please see Aetna's response to Question 4a above.

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?

Aetna follows relevant processes that CMS has implemented with respect to Exchange customer enrollment and subsidy information. Aetna does not have information that would allow it to independently determine the accuracy of premium subsidies. Aetna applies the subsidy amounts that CMS transmits to the Company in the 834 files. CMS may change those amounts from month to month for various reasons, including changes in an enrollee's income. When CMS makes such a change, they are sent to Aetna on an 834 file, and Aetna applies the change. CMS is the sole source of the relevant data and does not provide Aetna with information that would permit the Company to determine why a subsidy amount changed. Aetna does not retain federal subsidy payments for customers in the months where their coverage is no longer in effect.

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

Please see Aetna's response to Question 6a above.

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

Please see Aetna's response to Question 6a above.

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

Please see Aetna's response to Question 6a above.

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

Aetna does not separately track the administrative costs related to the handling of APTC changes.

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

Please see Aetna's response to Question 1B above.

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

Aetna has dedicated provider service centers with trained representatives who can answer questions from providers on the Affordable Care Act and other issues. Aetna also has built websites (including, e.g., http://www.aetna.com/health-reform-connection/reform-explained/) that provide information for providers and consumers regarding the ACA.

9. How many plans has your company sold off-exchange in 2014? Provide this information for each state in which you sell.

Please note that Aetna previously provided this information in a confidential submission to the Committee on June 25, 2014. This submission included such off-exchange information as of the end of the day on May 20, 2014.

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?

Aetna is currently using the interim payment process designed by CMS. CMS' final interim payment process has not yet been implemented.

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?

No, Aetna is not aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace 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?

Aetna has no insight into CMS' outstanding 834 transactions. The company receives 834 files from CMS on a daily basis, and processes all transactions accordingly.

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?

Aetna's dedicated customer service centers are available to help your constituents and Aetna's customers understand their desired plan's network coverage. The Company has also developed online sites specific to its exchange networks to help current and prospective customers understand which providers are part of the exchange network in their area. Examples of these sites can be viewed at: http://www.aetna.com/dse/search?site_id=QualifiedHealthPlanDoctors and http://fl.coventryproviders.com. The Company continues to work to enhance its provider directory search capabilities for ease of use by members.

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

Please see Aetna's response to Question 1a above.

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?

Please see Aetna's response to Question 1a above.

The Honorable Tim Murphy

1. Provide information on the number of plans your organization has sold in the Federally Facilitated Marketplace.

Please note that Aetna previously provided this information in a confidential submission to the Committee on May 29, 2014. This submission included such enrollment information as of the end of the day on May 20, 2014.

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Please note, as indicated above, that certain of the information provided in this submission is proprietary in nature, and we respectfully request that it be treated accordingly. Additionally, please note that certain of the responses included in today's submission refer to information that Aetna has previously provided in separate, confidential submissions to the Committee. As discussed with Committee staff, by referring to such information above, it is not Aetna's intention to incorporate it, by reference or otherwise, into today's submission, and we respectfully ask the Committee to preserve the confidentiality of this information. Moreover, we respectfully renew our request that Committee staff provide us with notice and an opportunity to be heard before the Committee discloses to third parties any such information, notwithstanding our requests to the contrary, contained in any previous confidential submissions. If the Committee intends to make any such information that we previously provided in connection with this inquiry public in any way, we respectfully request that all information be aggregated and de-identified. Further, should the Committee make any such information public in any way, we respectfully request that the information being provided be disclosed together with all accompanying legends, footnotes, and disclaimers, in order to avoid potential confusion over the comparability of the information provided, and any other information that Aetna may publicly disclose or other measures Aetna may disclose that may—in the absence of such clarifying notes—appear similar despite important differences in the basis of preparation. Our provision of the enclosed information is not intended to constitute a waiver of the attorney-client, attorney work product, or any other applicable rights or privileges, in this or any other forum, and Aetna expressly reserves its rights in this regard.

Please let me know if you have any questions.

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Steven R. Ross
Counsel for Aetna Inc.

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