December 18, 2015

Submitted electronically to regulations.gov

Sylvia M. Burwell
Secretary
Department of Health and Human Services

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services

Attn: CMS-9937-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Notice of Benefit and Payment Parameters for 2017 Proposed Rule

Dear Secretary Burwell and Acting Administrator Slavitt,

Aetna appreciates the opportunity to submit comments on the proposed rulemaking, HHS Notice of Benefit and Payment Parameters for 2017 (the "Notice"), issued by the Centers for Medicare & Medicaid Services ("CMS" or the "Department") on November 20, 2015 and published in the Federal Register on December 2, 2015. Aetna is one of the nation's leading diversified health benefit companies, providing members with resources to enable better informed decisions about their health. Aetna is committed to working with the Department to formulate rules that advance what we believe are consumers' top priorities in healthcare reform: affordability, competition and choice.

2017 is a critical year for the Health Insurance Marketplaces, marking the end of the temporary risk corridor and reinsurance program and the end of the "keep what you have policies". In order for the Marketplaces to be affordable to consumers and sustainable over time, it is critical that CMS' policies preserve the viability of the individual insurance market.

While the proposed rule takes some positive steps to do this,—such as the proposals regarding prescription drugs and preventive services in the risk adjustment program—

we remain deeply concerned that this Proposed Rule will not stabilize the individual market. Unless some fundamental flaws are corrected, we believe there is a grave risk that the federal Exchange will not operate as a viable, competitive market in 2017. Thus, we strongly recommend that CMS reconsider certain aspects of the proposed rule in the interest of promoting a stable risk pool, choice of affordable products, and innovation to benefit consumers.

This letter focuses on modifications that could improve the viability of the risk pool and promote consumer choice.

I. Preserving the Viability of the Risk Pool

Preserving the integrity of the risk pool is the single most critical factor in ensuring the viability of the federal Exchange in 2017.

A. Special Enrollment Periods

The annual open enrollment period and the individual mandate are the two fundamental cornerstones that made the ACA's guaranteed issue provisions possible. Inadequate enforcement of either of these pillars will result in higher premiums for consumers and ultimately unravel the marketplace.

Under current regulation, the proliferation and administration of the SEPs -- particularly for the Federally-facilitated Marketplace ("FFM") -- poses significant threats to the viability of the risk pool. Many individuals have no incentive to enroll in coverage during open enrollment, but can wait until they are sick or need services before enrolling and drop coverage immediately after receiving services, making the annual open enrollment period meaningless.

In 2015, 25% of all new on-Exchange applications received by Aetna/Coventry were received through a SEP. This high level of SEPs – combined with their unusually high claims generation – implies that individuals are not being held to compliance with either the open enrollment limitation or the individual mandate. The fact that CMS does not currently require any documentation before granting special enrolment eligibility is likely to be one driver of this. We also encourage CMS to monitor individual mandate compliance to protect against pool erosion – which would also likely diminish the level of special enrollments.

<u>Recommendations</u>:

- The FFM require and review documentation before granting eligibility for Special Enrollment Periods and CMS amend its regulations to require State-Based Exchanges ("SBEs") do the same.

- CMS should refrain from proposing additional SEPs, and should eliminate all of the SEPs that are tied to the operations of the FFM rather than true life events, with the exception of the SEPs for (1) decertification of a QHP mid-year and (2) enrollees that are newly eligible or ineligible for APTCs or CSRs.

B. Risk Adjustment

The effectiveness of risk adjustment is critical to the viability and stability of the individual market. Currently, issuers do not receive interim risk adjustment reports. This leads to dramatic financial "surprises" when the final numbers are received and this reduces the stability of the marketplace.

A separate issue is that the risk adjustment program currently uses total market average premium –which incorporates administrative costs. This unnecessarily increases the premium of low cost plans by as much as 2%. This negatively impacts choice and cost of plans for consumers.

Recommendations:

- Implement CMS proposals regarding preventive services and pharmacy data, and update its data to include partial-year enrollees.

- Provide interim risk scores, or transfer data throughout the course of the year.

- Amend the process to make it "benefit cost based" by eliminating administrative costs from the market average premium.

C. Third-Party Premium Payment

QHP issuers currently must accept third party premiums from a limited set of governmental (federal, state and local) programs and their grantees, which already exposes certain plans to significant adverse selection risk. Expanding these entities beyond the current scope of governmental programs (and their grantees) would significantly exacerbate this problem.

Recommendations:

- Do not expand the current universe of entities from which issuers must accept third party premium payments.

- If the Department continues in adopting an expanded rule, the Department should try to reduce negative impacts on the single risk pool as follows:

  - Require that all entities whose premiums must be accepted by QHP issuers self-identify their status prior to the QHP issuer accepting the premium payment, require that each and every payment provided by the third-party be marked as such, and permit issuers to reject any payment that is not so marked.

  - Provide QHP issuers with definitive lists, in advance of a plan year, of eligible third parties, in an effort to ensure that premium rates are accurately set, and that QHP issuers can protect against the adverse selection that is likely to occur for some plans.

II. Design Flexibility, Innovation, and Consumer Choice

A. Network Adequacy

The Secretary has promoted moving toward value based contracting and Aetna has committed to having 75% of our business in value-based arrangements with providers by 2020. The Department's network adequacy proposal undermines these goals by requiring inflexible federal standards in lieu of traditional state authority. The NAIC has recently released a carefully negotiated network adequacy model act that offers a much better template. The inflexible approach adopted in the Notice will necessarily constrain the growth of important innovations under the ACA, particularly Accountable Care Organizations ("ACOs") and simplified, more consumer-friendly products.

Recommendations:

- Adopt the network adequacy standards included in the NAIC model which provide strong consumer protections, but still allow the flexibility necessary for health plans to continue developing innovative and affordable networks, such as ACOs, for consumers. For example, the NAIC model does not mandate that time/distance and provider ratio criteria be used to determine network adequacy. Instead the model lists these as criteria that ***may*** be used, but

goes on to list a number of other criteria that are acceptable for determining adequacy. The model recognizes that time/distance and provider ratio criteria alone no longer provide the flexibility that is required for health plans to develop adequate and affordable networks for the varying geographies and populations they serve. This recognition is especially important given the development of new technologies and telehealth capabilities that have the potential to fundamentally transform how health care is delivered.

- Similar to the concerns expressed above, we do not believe that adding a "Network Coverage Rating", based on the number of providers within a certain time and distance, to healthcare.gov will provide meaningful or useful information for consumers in determining whether a health plan's network will meet their health care and affordability needs. Use of such a rating would lead consumers to believe that a broader network is a better network, which is not necessarily true. As the Secretary recently stated, "Narrow isn't bad if it's what you want and need."[1] In fact, early evidence suggests that properly constructed networks that work with a select group of providers, such as an ACO, can actually provide accessible care that is of higher quality and more affordable for consumers.

- Utilize other means of controlling the surprise billing issue, particularly through examination of its authority under the Medicare Conditions of Participation (COP) rules for hospitals that participate in Medicare. CMS has the authority under the Medicare COPs to help prevent surprise billing based on the Secretary's authority to apply, health and safety, (including financial), protections to *all* individuals getting services in a hospital that receives federal health care program dollars.

B. Standardized Plans

Aetna is a strong supporter of making key plan design features simple and transparent for consumers to better understand. However, the standardization proposed by the Department will inhibit innovation in plan design, prevent meaningful competition among issuers, and limit consumer options.

Recommendations:

- Do not pursue standardized plans.

[1] Zachary Tracer and Matthew Winkler, "Top Obamacare Official Makes Tweaks as Insurer Complaints Grow," *Bloomberg Business* website, November 24, 2015 (accessed 12/9/2015).

- Continue to allow issuers the flexibility to bring innovative product designs to market without tipping the scales in favor of standardized plans, essentially locking in today's common plan designs to the detriment of future innovation.

III. Student Health

While Aetna agrees with the Department's stated approach of continuing to support experience rating specific schools and groups of students within schools, the rate filing approach proposed by the Department would be both ineffective and highly burdensome. Aetna does not believe that the index rate setting methodology is feasible in an experience rated market or that it will provide either the Department or consumers with useful information about rates for student health coverage.

Recommendations:

- Do not implement an index rate based filing requirement for 2017.

- Outline the specific rating factors about which they are concerned and develop a more administratively feasible approach to identify their use.

The attached Addendum discusses these recommendations in more detail. Aetna appreciates the opportunity to comment on the proposed Notice. We would be happy to respond to follow up questions where needed.

Sincerely,

Steven B. Kelmar
Executive Vice President, Corporate Affairs

ADDENDUM to AETNA COMMENT LETTER
Detailed Technical Comments
Proposed Notice of Benefit and Payment Parameters for 2017

I. Preserve the Viability of the Risk Pool

Special Enrollment Periods:

The annual open enrollment period and the individual mandate are the two fundamental cornerstones that made the ACA's guaranteed issue provisions possible. Inadequate enforcement of either of these pillars will result in higher premiums for consumers and ultimately unravel the marketplace.

We appreciate that in the Notice, the Department asked for comments and data on abuses and problems associated with the current administration of special enrollment periods ("SEPs") for Qualified Health Plans ("QHPs"). Under the current regulation, the proliferation and administration of the SEPs, particularly for Federally-facilitated Marketplace ("FFM"), poses significant threats to the viability of the risk pool. Many individuals have no incentive to enroll in coverage during open enrollment, but can wait until they are sick or need services before enrolling and drop coverage immediately after receiving services, making the annual open enrollment period meaningless – and essentially nullifying the individual mandate.

Our first concern is that the 40+ SEPs for on-exchange coverage far exceed the traditional SEP categories used off exchange. The extensive SEPs -- which far exceed the statutorily-required SEPs -- leave individuals with little incentive to enroll in coverage during open enrollment, since they can wait until they are sick or need services before enrolling and drop coverage immediately after receiving services.

This gaming behavior is facilitated because the FFM does not require documentation or verify eligibility for SEPs. In 2015, 25% of all new on-Exchange applications received by Aetna/Coventry were received through a SEP. This high level of SEPs – combined with their unusually high claims generation – implies that individuals are not being held to compliance with either the open enrollment limitation or the individual mandate.

On-exchange, issuers are not allowed to verify documentation. Compare this with off-exchange products (where an issuer verifies SEP eligibility directly). In off-exchange scenarios, we find that 15- 30 percent of SEP applicants do not produce documentation for SEP when requested.

It is likely that the number of SEP enrollees that are unable to validate their SEP eligibility is even higher in the exchange context, because applicants that cannot validate their SEP eligibility are likely to know that the FFM will not require proof of SEP eligibility. So, the result of the current SEP administration for the FFM is enrollment of a significant number of individuals who may not actually be eligible for an SEP, and who could and should have enrolled in coverage during the annual open enrollment period. We have observed a number of members whom we earlier terminated for non-payment of premiums return in a few months through a SEP. On average, SEP enrollees stay with us for less than four months, while enrollees who come to us during the annual open enrollment period maintain their coverage on average for eight to nine months.

With such a high percentage of exchange enrollees purchasing coverage through SEPs, the integrity of the annual open enrollment period is threatened. This in turn threatens the viability of this single risk pool by exposing it to adverse selection and gaming throughout the year. We encourage CMS to monitor both open enrollment as well as individual mandate compliance to protect against pool erosion.

The Department suggests that its proposal to permit an Exchange to cancel an enrollment retroactively would help address fraudulent enrollments. While Aetna appreciates efforts by the Department to address these issues retroactively, as proposed in the Notice, changes are required at the application stage to ensure that gaming of the system is eliminated before claims are incurred. Moreover, retroactive cancellation of coverage is difficult and resource-intensive. It requires issuers to identify improper claims before payments are made (which is usually not possible), or to attempt to recover improperly paid claims from providers (which angers providers and cannot usually be done with regard to prescription drugs), and may affect any advance premium tax credit or cost-sharing reductions the enrollee may have improperly received. It would be more efficient, and certainly less costly, to prevent these enrollments in the first place.

- **Recommendation:** Aetna recommends that

    - The FFM require documentation and verify eligibility for Special Enrollment Periods and CMS amend its regulations to require State-Based Exchanges ("SBEs") do the same. If the FFM (or SBE) is unable to implement a verification process for SEPs, Aetna recommends that QHP issuers be given the authority to conduct these determinations. If an issuer is required to assume this verification process, CMS (and SBEs) should be required to reduce the exchange user fee charged.

- CMS should refrain from proposing additional SEPs, and should eliminate all of the SEPs that are tied to the operations of the FFM rather than true life events, with the exception of the SEPs for (1) decertification of a QHP mid-year and (2) enrollees that are newly eligible or ineligible for APTCs or CSRs.

Risk Adjustment:

The effectiveness of risk adjustment is critical to the viability and stability of the individual market. The Notice describes the Department's intended approach of including preventive services in the risk adjustment methodology, using more recent data to calibrate the methodology, and considering approaches to include pharmacy data to document conditions when diagnostic data is missing or insufficient. Aetna strongly supports these initiatives, and believes that the use of preventive services will more accurately reflect risk of healthier individuals. Aetna also supports updating the methodology to reflect partial year enrollees. We believe that these updates will more accurately reflect risk profiles in the market.

Aetna has also identified two other issues and recommends that CMS consider as it develops the Final Rule. First, Aetna believes that providing interim risk scores or transfer data through the course of the year will inform issuers of how the market risk score is developing and provide greater transparency into how the risk adjustment program will impact issuers through the course of the year. Second, Aetna proposes that CMS amend the transfer formula to eliminate administrative costs from risk adjustment payments. The Notice did not propose any changes to the transfer formula, but did restate the transfer formula, which currently relies on market average premium. Aetna proposes that the formula be altered to rely on market average claims, or some other metric that accurately reflects risk, but does not spread the administrative costs of less efficient plans to more efficient plans.

- **Recommendation:** Aetna recommends that:

  - The Department finalizes its proposals regarding preventive services and pharmacy data, and that the Department updates its data to include partial-year enrollees.

  - The Department should provide interim risk scores, or transfer data throughout the course of the year.

  - The Department should amend the transfer formula to eliminate administrative costs from risk adjustment payments. Specifically, the transfer formula should

use market average claims or its proxy (market average premium multiplied by .8) to remove administrative expenses from the formula.

Third-Party Payment:

The Notice requested comment on whether or not the Department should expand the universe of third-party premium payers from whom QHP issuers must accept premiums to include not-for-profit entities. Aetna strongly opposes expanding the types of entities from whom QHP issuers must accept third-party premium payment. Under the current rules, QHP issuers must accept third party premiums from a limited set of governmental (federal, state and local) programs and their grantees. This limited universe of entities already exposes certain plans to significant adverse selection risk.

Expanding these entities beyond the current scope of governmental programs (and their grantees) would exacerbate this problem significantly for two primary reasons. First, by using not-for-profit status as the metric for acceptance of third-party premium payment, the Department would require that QHP issuers accept payment from a wide variety of entities whose interest are to cover individuals whose risk is disproportionately high, but who may not have the resources (or institutional mandate) to provide coverage continuously. Second, from an administrative perspective, expanding this universe will pose significant burdens on issuers, who will be called upon to determine the validity of an entity's status as not-for-profit, and be required to develop systems to track third-party payers, even though most issuers currently have no way of knowing if the payment is made by a third-party.

Expanding the universe of third-party payers from whom issuers must accept payment would also encourage for profit entities and facilities to take advantage of the third-party premium payment policy (and administrative problems in identifying and verifying required third-parties) further degrading the single risk pool.

- **Recommendation:** We recommend that the Department not expand the current universe of entities from which issuers must accept third party premium payments. If the Department continues to adopt an expanded rule, the Department should reduce the impact on the integrity of the risk pool through the following:

    - Require that all entities whose premiums must be accepted by QHP issuers self-identify their status prior to the QHP issuer accepting the premium payment, require that each and every payment provided by the third-party be marked as such, and permit issuers to reject any payment that is not so marked.

- Provide QHP issuers with definitive lists, in advance of a plan year, of eligible third parties, in an effort to ensure that premium rates are accurately set, and that QHP issuers can protect against the adverse selection that is likely to occur for some plans.

II. Design Flexibility, Innovation, and Consumer Choice

Network Adequacy:

Aetna has considerable concerns with the Department's proposed network adequacy standards. The proposal effectively mandates more inflexible federal standards in lieu of traditional state authority (*i.e.*, chiefly through the imposition of mandatory federal metrics such as time/distance). Instead, Aetna strongly supports the NAIC Model Act's approach. The NAIC has recently released a carefully negotiated network adequacy model act that offers a much better template, because it leaves greater flexibility to state regulators who are closer and more responsive to local markets and delivery systems. Furthermore, the NAIC model act reflects years of negotiation among very diverse stakeholders – including payors, consumers, and providers, and represents the consensus of these varied stakeholders. Last year the Department signaled that it intended to defer to NAIC on network adequacy where possible, saying:

> We expect that the final product of the NAIC work will reflect the viewpoints of the various stakeholders. This reflects our general position that network adequacy is an area subject to significant State regulation and oversight.

This year's proposed NBPP does not follow that policy.

Importantly, the inflexible approach adopted in the Notice will constrain the growth of important innovations envisioned to be legacies of the ACA, including Accountable Care Organizations ("ACOs") and simplified, more consumer-friendly products. Rather than constrain these types of plans through inflexible network adequacy rules, Aetna recommends the Department defer to the state approaches that are part of the NAIC's Network Adequacy Model Act. Similarly, the use of federally dictated metrics runs counter to the need for state flexibility embodied in the NAIC approach. In particular, network adequacy requirements must reflect the significant geographic and demographic differences among states and localities.

Like the Department, Aetna agrees that balance billing of patients for emergency or surprise out-of-network services is problematic. In fact, our contracts contractually commit us to hold members harmless for out-of-network emergency services. However, the Department's proposal to apply the out-of-network cost-sharing to member annual in-network out of pocket maximums would be counterproductive and does not

adequately address the problem. We are concerned that the inclusion of this provision would yet further discourage certain providers from contracting with insurers – exacerbating costs in these areas and further increasing premiums. There are alternative regulatory actions that would have a more constructive impact, as specified below.

- **Recommendation:** Aetna recommends that the Department

  - Adopt the network adequacy standards included in the NAIC model which provide strong consumer protections, but still allow the flexibility necessary for health plans to continue developing innovative and affordable networks, such as ACOs, for consumers. For example, the NAIC model does not mandate that time/distance and provider ratio criteria be used to determine network adequacy. Instead the model lists these as criteria that ***may*** be used, but goes on to list a number of other criteria that are acceptable for determining adequacy. The model recognizes that time/distance and provider ratio criteria alone no longer provide the flexibility that is required for health plans to develop adequate and affordable networks for the varying geographies and populations they serve.

  - Similar to the concerns expressed above, we do not believe that adding a "Network Coverage Rating", based on the number of providers within a certain time and distance, to healthcare.gov will provide meaningful or useful information for consumers in determining whether a health plan's network will meet their health care and affordability needs. Use of such a rating would lead consumers to believe that a broader network is a better network, which is not necessarily true. In fact, early evidence suggests that properly constructed networks that work with a select group of providers, such as an ACO, can actually provide accessible care that is of higher quality and more affordable for consumers.

  - Utilize other means of controlling the surprise billing issue, particularly through examination of CMS authority under the Medicare Conditions of Participation rules for hospitals that participate in Medicare. CMS has the authority under the Medicare COPs to help prevent surprise billing based on the Secretary's authority to apply, health and safety, (including financial), protections to *all* individuals getting services in a hospital that receives federal health care program dollars.

Standardized Plans:

Aetna is a strong supporter of making key plan design features simple and transparent for consumers to understand. However, Aetna does not support the standardized plan

approach proposed in the Notice. Even though Aetna is currently working to include plan design features similar to those outlined by the Department, the standardization proposed by the Department will inhibit innovation in plan design, prevent meaningful competition among issuers, and limit consumer options (both in terms of benefits and cost-sharing).

Furthermore, Aetna has significant concerns with the data relied upon by the Department in developing the standardization proposal. By relying on studies of the Medicare population, and their tolerance for multiple choices, the Department may overstate the extent to which multiple choices, and variance among choices, affect FFM enrollment. The presence of standardized plans will also detract from the exchange user experience. There will be more, not less, plan options from which to choose, further complicating (as opposed to simplifying) the consumer experience.

Specifically, although Aetna agrees that network tiering is conceptually complicated for consumers, it can be an important tool in offering high-quality, cost-effective coverage. Similarly, Aetna believes that locking-in certain cost-sharing features, whether limiting the use of coinsurance (a plan design Aetna is already employing), or guaranteeing in-network payments for certain types of services, like behavioral health, will have detrimental effects on consumers. Aetna also notes that these cost-sharing requirements have two direct effects: first, issuers whose systems are not designed to deal with a given type or level of cost-share for a specific benefit, will have few incentives to offer a standardized plan, effectively driving those issuers to withdraw from the FFM. Second, the administrative complexity of offering such plans will necessarily increase as issuers will be forced to rely on annual updates to certain cost-sharing levels by the Department.

Importantly, Aetna notes that Actuarial Value, metallic tiering, and Essential Health Benefits requirements provide the three most important data points for consumers to categorize coverage, and serve as a standard baseline upon which consumers can choose coverage (and issuers can develop innovative plans). As a result, Aetna encourages the Department to consider the myriad effects of standardization on both the exchange user experience and individual's likelihood to actually purchase coverage that meets their unique needs.

- **Recommendation:** Aetna urges the Department to:
    - Not pursue standardized options.

- Continue to allow issuers the flexibility to bring innovative product designs to market without tipping the scales in favor of standardized plans, essentially locking in today's common plan designs to the detriment of future innovation.

III. Student Health

Aetna also has significant concerns with the Department's proposal to require student health issuers to file the single risk pool rates with actuarial justification for any differences in rates. While Aetna agrees with the Department's stated approach of continuing to support experience rating specific schools and groups of students within schools, the rate filing proposed by the Department would be both ineffective and highly burdensome. Aetna does not believe that this approach is feasible in most cases, and that the information gleaned will be ineffective in providing the Department and consumers with valuable information about rates for student health coverage.

The Department's stated rationale for the proposal lies in the Department's concern over the use of impermissible factors by some issuers in their student health rating. Aetna recommends a more effective, less burdensome approach to address these issues.

- **Recommendation:** Aetna recommends that the Department not implement an index rate based filing requirement for 2017, and outline the specific rating factors about which they are concerned and develop a more administratively feasible approach to identify their use.