November 22, 2017


The Honorable Eric Hargan
Acting Secretary
U.S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

ATTENTION: CMS-9930-P

Re: HHS Notice of Benefit and Payment Parameters for 2019; Proposed Rule

Dear Acting Secretary Hargan:

Anthem, Inc. (Anthem) appreciates this opportunity to comment on the U.S. Department of Health and Human Services’ (HHS) Notice of Benefit and Payment Parameters (NBPP) for 2019 proposed rule, published in the Federal Register on November 2, 2017. We also take this opportunity to comment upon the Draft Example of an Acceptable Methodology for Comparing Benefits of a State’s EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan as Proposed under the HHS Notice of Benefit and Payment Parameters for 2019, issued on October 27, 2017. As a committed participant in the health insurance market, Anthem looks forward to working with HHS and the Centers for Medicare & Medicaid Services (CMS) to find innovative solutions to the challenges currently facing the individual and small group markets.

Anthem is one of the nation’s leading health benefits companies, serving over 74 million people through its affiliated companies, including more than 40 million within its family of health plans. Specific to the individual and small group markets, Anthem serves nearly two million in the individual market and over one million in the small group market today.
As described in our priority issues below, Anthem strongly supports many of the proposals that HHS has made to afford greater flexibility to states and issuers, and to remove existing regulatory barriers so that issuers can offer a more diverse selection of coverage options that meet both the financial and health coverage needs of consumers. We do, however, have concerns that the proposals are insufficient to stabilize the volatile individual market and a number of the proposals may result in some unintended adverse consequences that further destabilize the marketplace. We urge the Administration to focus on three areas to stabilize the individual market: (1) a balanced risk pool that includes enough consistently enrolled healthy individuals, (2) a predictable and stable regulatory environment with sufficient time to react to any changes, and (3) predictable and stable sources of funding that ensure affordability. We value the partnership that we have developed with HHS and appreciate the opportunity to provide Anthem’s perspectives on the proposed rule, including our recommendations for addressing the concerns that we have identified that include the following key areas:

- **An Accurate Risk Adjustment Program is Critical for Stability in a Community Rated, Guaranteed Issue, and Single Risk Pool Market:** Anthem supports HHS’ proposal to continue with the change made for 2018 to remove fixed administrative costs from the statewide average premium. It is critical that HHS continue this improvement for the 2019 benefit year and beyond so that the model is more accurate and issuers have equal incentive to enroll all populations. Anthem is vehemently opposed, however, to the proposal to provide state flexibility to reduce risk adjustment payment transfers for the small group (and possibly individual) market. This proposal would reduce the effectiveness of the risk adjustment program, work against accuracy of the program, and would increase instability for consumers by creating incentives for some issuers to engage in practices that result in risk segmentation.

- **Elimination of Standardized Plan Options Will Allow Issuers to Offer Higher Quality, More Affordable Coverage Options:** Anthem supports HHS’ decision to eliminate standardized plan options for 2019. We have long held the position that standardized plans impede innovative product design and have the potential to mislead consumers by representing as equivalent, plan options that have meaningful differences, such as formulary coverage or network. We believe that elimination of the standardized plan options will better enable issuers to design products that both meet consumers’ needs and reflect the intricacies of state law and local market dynamics.

- **Allowing States to Update Essential Health Benefit (EHB) Benchmark Plans Annually and Select From Additional Benchmark Plan Options May Result in Less Affordable Coverage and Consumer Confusion:** While Anthem supports HHS’ goal of affording states greater flexibility to regulate their individual and small group insurance markets, we are concerned that allowing states to substitute benchmark plans and/or EHB categories on an annual basis may lead states to expand benefits under their benchmark plans without defraying the costs of such
benefits, increasing the cost of coverage. We further believe that the lack of predictability that would come with annual updates to EHB-benchmark plans will result in confusion for consumers who have come to rely on some consistency among plan benefit packages from year to year.

- **Affording Issuers Flexibility to Substitute Benefits Across EHB Categories May Lead to Gaming and Confusion for Consumers**: Anthem appreciates HHS’ efforts to give issuers greater flexibility with respect to benefit design. We are concerned, however, that allowing issuers to substitute benefits across EHB categories could lead some issuers to design plans that are unattractive to higher-cost, more complex populations, resulting in adverse selection that would further destabilize the marketplace. We also believe that the lack of uniformity that would result from benefit substitution would make it difficult for consumers to make meaningful comparisons among plans and cause consumer confusion.

- **Value-Based Insurance Design and High Deductible Health Plan-Health Savings Accounts Could Expand Coverage Opportunities for Enrollees While Promoting the Use of High-Value Providers and Services**: Anthem shares HHS’ commitment to identifying and implementing innovative, cost-effective approaches to benefit design, including Value-Based Insurance Design (VBID). HHS can promote the development of plans that include VBID elements by affording issuers greater flexibility to detail VBID benefits in enrollee communications, including Summaries of Benefits and Coverage (SBCs), and to design plans customized to certain conditions and/or enrollee populations and which drive the utilization of high-value services and effective treatments. We also recommend that HHS help issuers encourage consumers with chronic conditions to utilize high-value services and effective treatments available under High Deductible Health Plan (HDHP)-Health Savings Accounts (HSAs) by expanding the current Internal Revenue Service (IRS) safe harbor that allows HDHPs to provide pre-deductible coverage of preventive services to include services and treatments for consumers with such conditions.

- **Future Rulemaking Addressing Program Integrity Provides HHS the Opportunity to Promote Market Stabilization by Preventing Individuals Eligible for Public Program Coverage from Enrolling in Individual Market Coverage**: Anthem is supportive of HHS’ statement that it is proposing future rulemaking and guidance aimed at improving exchange program integrity and has asked for feedback on ways to safeguard the federal dollars that flow through exchanges. We are particularly interested in HHS’ proposal to implement processes for matching exchange enrollment data with Medicare and Medicaid programs. We also urge HHS to take this opportunity to issue a proposed rule aimed at prohibiting third party premium payments that inappropriately steer Medicare and Medicaid beneficiaries to the individual market.
Accounting for All Fraud Prevention, Detection and Recovery Expenses in the Medical Loss Ratio Calculation Can Improve Health Outcomes and Lower the Cost of Insurance.

Disallowing issuers’ fraud prevention expenses in the commercial Medical Loss Ratio (MLR) calculation has severely weakened the incentive for issuers to maintain robust anti-fraud programs and has contributed to the overall cost of health insurance. In its proposed Medicare Rule released on November 16, HHS proposes to allow Medicare Advantage plans to include expenses for fraud prevention, detection, and recovery in the Medicare MLR calculation. Fraud prevention programs should be encouraged and supported in both public and private health care programs so that fraud is consistently controlled throughout the health care industry.

We also encourage the Administration to consider the significant impact that a repeal or weakening of the individual mandate will have on the individual market. If the mandate is weakened or repealed, without changes to the market rules or additional provisions that encourage continuous coverage, the individual market will be further destabilized with negative consequences for consumers.

Anthem requests that HHS consider these priority issues, as well as the provisions we identify below, and finalize the rule as soon as possible to ensure that issuers have sufficient time to acclimate to the final policies and procedures and offer consumers the best possible experience in 2019.

RISK ADJUSTMENT AND RISK ADJUSTMENT DATA VALIDATION (§153)

Risk Adjustment Model Calibration (§153.320)

Issue: HHS intends to continue with its previously outlined proposal for recalibrating the 2019 risk adjustment model with three years of data: 2014 and 2015 from the MarketScan data set and 2016 from EDGE data. HHS believes using EDGE data will generally be a more accurate representation of the individual and small group population because MarketScan predominantly reflects the population covered in the large group market.

For the final 2019 model coefficients, HHS proposes to equally weight separately solved coefficients from the 2014 MarketScan, 2015 MarketScan, and 2016 enrollee-level EDGE data. HHS seeks comments on whether adjustments to the calibration should be made if HHS finds significant demographic or distributional differences between the two data sources.

Recommendation: Anthem supports using enrollee-level EDGE data to recalibrate the risk adjustment model. Crucial in this regard is that recalibration using EDGE data relies on methods that protect consumer privacy and maintain the proprietary and confidential nature of issuers’ data while also allowing for data-driven approaches to improve the predictive ability of the model. Anthem recommends that HHS provide more detail on which specific data elements are being pulled from issuers’ EDGE servers including how
HHS is ensuring that this data is kept confidential such that no enrollee, issuer, or provider will be identifiable in the data set that HHS will now be maintaining.

Additionally, if HHS finds significant demographic or distributional differences in the EDGE data compared to the MarketScan data, Anthem supports HHS making adjustments to give greater weight to the EDGE data when recalibrating the model coefficients.

**Rationale:** Anthem supports using enrollee-level EDGE data so that the underlying risk adjustment model provides a more accurate representation of the individual and small group markets. There could be significant differences in the cost and utilization profiles between the individual and small group markets as reflected in the EDGE data compared to the large group market data that is available through MarketScan.

Anthem understands and appreciates the need to phase in EDGE data and to continue to incorporate 2014 and 2015 MarketScan data to ensure some year-over-year stability in the coefficients and adequate sample size in certain subpopulations. That said, in cases where there are significant differences between MarketScan and EDGE data, Anthem does support HHS giving greater weight to EDGE data if there is an adequate sample size to confirm any differences. This will improve the underlying model so that it is a more accurate representation of the individual and small group markets. Anthem also supports using additional years of EDGE data as it becomes available and phasing out the use of MarketScan data in the future. Anthem recommends that HHS analyze the EDGE data to study key differences between the individual and small group markets including costs, utilization patterns, induced demand, and partial year enrollment. This analysis could help inform future improvements to the model such as potentially using different coefficients for the individual versus small group markets.

Anthem should limit the data elements collected to only those necessary for model recalibration, and should not collect any data that would allow for the identification of the enrollee, issuer, or provider. The EDGE data that will be used for model calibration is very sensitive and should be treated as such. Requiring health plans to provide to HHS (or any third party) access to detailed enrollee-level data carries significant risks for consumer privacy and proprietary information such as provider contracted rates, which is incredibly important to keep confidential to avoid anti-competitive behavior that would increase costs for consumers. Given the confidential and proprietary nature of the data, HHS should limit the use of this data to only improving risk adjustment and the Actuarial Value calculator, and prohibit any other uses without express permission from issuers.

**Pharmacy Data in the Risk Adjustment Model (§153.320)**

**Issue:** HHS proposes to continue incorporating prescription drug data for certain diagnoses for the risk adjustment model, but will modify the approach from last year by eliminating two of the prescription drug categories (RXC) (11-Ammonia Detoxicants and Diuretics, Loop, and 12-Select Potassium-Sparing).
This is suggested because after HHS applied the average cost constraints to those drugs, it found the factors no longer predicted a meaningful incremental plan risk. The two eliminated RXCs were severity-only RXCs which must be paired with a documented diagnosis for the RXC to add to the risk score.

**Recommendation:** Anthem supports HHS eliminating the two severity-only RXC factors from the 2019 risk adjustment model given the projected small magnitude of these coefficients; however, we also recommend that HHS confirm that the impact of including the two RXCs remains insignificant once the 2016 EDGE data is added to the model. Beyond 2019, HHS should continue to explore whether existing RXCs that have relatively low impact in predicting meaningful plan risk might also be eliminated, while contemplating the addition of RXCs that would further increase the model’s accuracy.

**Rationale:** Anthem supports using drug utilization data in the risk adjustment model. A key benefit from the use of prescription drug data is that it can help fill in the gaps where diagnoses may be missing due to under-recording in medical claims or encounter data. Prescription drug utilization data is generally high quality, is available in a timely manner with minimal administrative cost, and represents a more complete picture of an enrollee’s health profile, especially for chronic conditions that do not require frequent physician visits. Now that RXCs have been incorporated into the risk adjustment model, we recognize that HHS will need to update them based on additional analysis and issuer experience. Anthem encourages HHS to contemplate not only which RXCs are no longer appropriate for inclusion, but also which additional RXCs could be added to make the model more accurate. Two drug classes that Anthem would propose for consideration to add to the model would be growth hormones and antipsoriatics. Given the amount of pharmacy benefit spending for individuals with conditions treated by these drugs, we believe these two RXCs could add meaningful value to the overall model accuracy.

**High-Cost Risk Pool Adjustment (§153.320)**

**Issue:** HHS proposes to use the same high-cost risk pool parameters for 2019 as were proposed for 2018: $1 million threshold and 60 percent coinsurance rate. HHS seeks additional feedback on the structure of the high-cost risk pool, including whether the pool should be multi-tiered, with multiple thresholds and increasing coinsurance as the thresholds increase.

**Recommendation:** Anthem supports the continuation of the high-cost risk pool adjustment with the existing parameters and funding approach. We would caution against changing the program parameters drastically from one year to the next, as this could result in program instability. We believe that using a tiered approach creates unnecessary complexity and is not required at this time, but we encourage HHS to study this approach for future years.

**Rationale:** The exclusion of high-cost enrollees from the risk adjustment model improves the model’s overall predictive capabilities. We also support the national approach to funding this aspect of the risk
adjustment program because it helps to maintain a balance between the level of assessments applied to support the program and the allowance for some risk-pooling across states or geographic areas.

For the 2019 benefit year, we do not recommend that HHS tier or step up the coinsurance rate for higher levels of claims costs. HHS will first implement the high-cost risk pool adjustment for the 2018 benefit year and therefore stakeholders do not yet have any experience with which to evaluate and assess the existing program parameters and the impact on the market. We believe tiering the coinsurance rates at this time introduces change, and unnecessary complexity, where none may be needed. We suggest HHS delay any action on this proposal until issuers have adequate experience under the existing program parameters to determine what, if any, modifications are warranted.

**Administrative Cost Reduction to Statewide Average Premium (§153.320)**

**Issue:** HHS proposes to continue the policy finalized in the 2018 NBPP to reduce the statewide average premium in the risk adjustment transfer formula by 14 percent to account for the proportion of administrative costs that do not vary with claims for the 2019 benefit year and future benefit years.

**Recommendation:** Anthem strongly supports HHS reducing the statewide average premium to account for costs associated with administrative expenses that do not vary with claims.

For future years, we recommend that HHS consider moving towards an approach that relies on market average costs or claims experience and adds on a claims-related adjustment to account for administrative costs that can vary with the level of claims experience (e.g., expenses related to adjudication or medical management). To assist with implementation of this approach, we suggest that HHS ask the American Academy of Actuaries to recommend a specific approach for achieving this goal. The recommended approach could be part of a broader white paper on risk adjustment improvements for future years which is described in greater detail at the end of this section.

**Rationale:** This reduction to the statewide average premium was a critical and much needed improvement to the risk adjustment methodology for the 2018 benefit year. With this improvement, there are balanced incentives for issuers to enroll both the healthy and the sick. Prior to 2018, where the risk adjustment methodology did not include this adjustment, the revenue for healthier members was insufficient to fund costs after risk adjustment charges. Under this proposal, the accuracy of risk transfers is increased by excluding the impact of fixed administrative costs on statewide average premium. It is critical that HHS continue this improvement for the 2019 benefit year and beyond so that the model is more accurate and issuers have equal incentive to enroll all populations.
State-Specific Reductions to the Statewide Average Premium (153.320)

**Issue:** For states that can demonstrate that actuarial risk differences due to adverse selection are mitigated by the dynamics of the state’s small group market, HHS proposes to allow state insurance regulators to request a percentage adjustment in the calculation of the small group risk adjustment transfer amounts by up to 50 percent for the applicable year beginning for the 2019 benefit year. HHS specifically seeks comments on whether this flexibility should be extended to the individual market.

States seeking reductions would submit their request and actuarial analysis to HHS within 30 days after publication of the proposed NBPP for the applicable benefit year. HHS will then publish these requests for public comment and make final determinations by March 1, prior to the applicable benefit year.

**Recommendation:** Anthem is vehemently opposed to state-specific adjustments to the transfer formula for both the small group and individual markets. While Anthem supports state flexibility in many areas for the individual and small group markets, we believe adopting such an approach would have a destabilizing effect on the market. This could lead to increased premiums for small employers and consumers where issuers with higher risk populations are not adequately compensated for their risk. As HHS identifies in the preamble, states already have the opportunity to take responsibility for the risk adjustment program for their state if they believe the federal program is not reflective of their market. If a state believes that the federal risk adjustment model is detrimental to their market, the policy solution is for the state to develop its own risk adjustment program to address any potential deficiencies rather than pursuing this blunt approach that likely will not address the problem, and will create unintended, catastrophic consequences for the market as a whole.

**Rationale:** The overall policy goal of the risk adjustment program is to mitigate the potential impact of adverse selection and to stabilize the price of health insurance in the individual and small group markets, both on and off exchanges. Program results to date clearly show that risk adjustment has been effective in directional transfers from issuers with predominantly “low-risk” members to those that have a disproportionate share of “high-risk” members. For example, both the 2015 and 2016 HHS risk adjustment payment reports highlight a very strong correlation between amount of paid claims and likelihood that an issuer was assessed a risk adjustment charge or received payments.¹

This proposal, if implemented, carries the danger of resulting in inadequate risk adjustment funding which would lead to increased premiums for small employers and consumers. Issuers with a disproportionate share of higher-risk enrollees, who are risk adjustment “receivers,” could have inadequate premium

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revenues to cover claims costs if risk adjustment transfers required of the “payers” are reduced under this proposal. This will lead to higher rate increases in subsequent years and will have a destabilizing effect on the market. In the 2017 benefit year and for prior years, Anthem agrees that use of the full statewide average premium in the transfer formula resulted in inaccurate transfers between issuers because of the inclusion of fixed administrative costs in the premium. However, HHS has addressed that issue separately, and this proposal to permit states to reduce small group transfers by up to 50 percent would result in issuers with a disproportionate share of high-risk members having to increase premiums to account for the shortfall in risk adjustment transfers.

Furthermore, issuers would no longer have an equal incentive to enroll all populations under this proposal. Instead, some issuers might try to enroll certain types of small employers (or consumers in the individual market) viewed as healthier or less costly, which would be harmful to the overall stability of these markets. This could be done by targeting certain industries and/or certain sized employers through marketing (or avoiding certain “unattractive” employers through lack of marketing). While the small group market is less prone to adverse selection given employer contribution to premiums, participation rules and other dynamics, adverse selection would likely still occur in the community rated, guaranteed issue, single risk pool small group market that exists today.

HHS discusses in the preamble how certain small group market dynamics result in less risk selection in the small group market, including employer contribution to employees’ health insurance premium and minimum participation rules. This is reflected in generally lower risk scores in the small group market. However, we fail to see how these specific dynamics would lead to overcompensation for risk differences in the small group market for a particular state. We believe any differences in risk scores across issuers within a market are a reflection of adverse selection. And as such, risk adjustment is critical for those issuers with a higher risk small group population, especially in the context of a community rated, guaranteed issue, single risk pool.

In a recent blog post, Oliver Wyman used 2015 risk adjustment data to analyze risk adjustment in the small group market and show the impact on 2015 risk adjustment transfers if states had reduced risk adjustment payment transfers by 50 percent as proposed by HHS. After analyzing the 2015 data, Oliver Wyman concluded that in 2015 the risk adjustment system was instrumental in allowing plans to compete based on features other than risk selection. In addition, the analysis revealed that if 2015 risk adjustment transfers had been reduced by half, the risk adjustment system would have been less effective in compensating plans with high-cost enrollees and would have increased incentives for plans to attract healthy enrollees and avoid those likely to require significant medical care.

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If the cost difference between lower risk and higher risk enrollees (or for certain conditions) is different within the state than is reflected in the coefficients based on the national database due to local medical practices, for example, the more appropriate solution would be for the state to develop its own risk adjustment coefficients, as is already allowed under existing regulations. However, a flat percentage adjustment as proposed is not likely to accurately account for these differences.

Anthem also strongly opposes extending this policy to the individual market. For the same reasons outlined above, there is too much risk that this policy change could result in inadequate risk adjustment funding which would lead to increased premiums, as well as possible reductions in plan choice for consumers. It likely would also incentivize cherry-picking behavior by some issuers further destabilizing an already fragile market. We note that the individual health insurance market is even more susceptible to risk segmentation without a meaningful risk adjustment program. The current risk adjustment methodology is based on well-established practices of risk adjustment. It provides a fair and objective method of transferring money between competitors and HHS should not extend this proposed policy change to the individual market.

While we reiterate our resolute opposition to such an approach for the small group and individual markets, if HHS were to decide to grant such state flexibility, HHS should consider the following as part of implementation:

- The proposed March 1, 2018 deadline for finalizing any state percentage adjustments is unworkable, as the quarterly 2018 small group rate filings would already be in effect. This deadline also does not provide issuers enough time to incorporate such an approach into rate development and state rate filings for the individual market. Anthem recommends that state applications for adjustments to the statewide average premium be submitted within 30 days after the release of the risk adjustment transfer report or no later than August 1. HHS could then announce finalized state adjustment approaches in the Final NBPP each year. If HHS decides to implement this overall proposal for the small group market, implementation should be delayed at least until the 2020 benefit year.

- States should be required to submit an actuarial report demonstrating the extent to which transfer amounts calculated pursuant to the risk adjustment methodology finalized for the applicable benefit year (including the changes incorporated during the 2017 and 2018 benefit year) would overstate differentials in uncompensated predicted risk. The preamble notes that the HHS risk adjustment methodology predicts average group costs to account for risk across plans, which accords with Actuarial Standard of Practice (ASOP) 12, Risk Classification. The actuarial report should include an attestation that the percentage reduction in payment transfers requested results in a risk adjustment methodology that continues to comply with ASOP 12 and include an assessment of the effects of adverse selection that may result from the implementation of the
payment transfer reduction. The report should provide evidence that issuers with outlier results paying in to risk adjustment are appropriately coding and that operational issues did not contribute to their risk adjustment results.

- We agree with a public comment period for consumers and issuers to provide feedback on the state-proposed adjustments. It is critical that the states and HHS be as transparent as possible, with details expressly set forth allowing enough time for stakeholders to provide feedback. This will ensure transparency, stability, predictability, and a level playing field in the market to the greatest extent possible under this approach.

Payment Adjustment for Error Rates (153.630)

**Issue:** HHS proposes to evaluate statistical deviation in error rates when determining whether to apply error rates to an issuer’s risk scores beginning with the 2017 Risk Adjustment Data Validation (RADV) process. Adjustments would only be made if an issuer’s error rate materially deviates from a statistically meaningful value (e.g., mean or typical value) nationally. If an error rate materially deviates from a central tendency, the full error rate would not be used to adjust an issuer’s risk scores. Rather, HHS would apply the difference between the mean error rate or confidence interval and an issuer’s calculated error rate. HHS is also contemplating conducting this analysis at the Hierarchical Condition Category (HCC) or groups of HCCs level and determining the deviation accordingly.

**Recommendation:** Anthem is supportive of HHS limiting adjustments to only those instances in which an issuer’s error rate materially deviates from a statistically meaningful value and suggests the deviation be determined at the issuer level and not split by Hierarchical Condition Categories (HCCs) or groups of HCCs in the short-term. We encourage HHS to study the impact of assessing the deviation at the HCC, group of HCCs, or some combination of these levels in future years.

Additionally, Anthem supports limiting the implementation of the error rate for purposes of subsequent year risk score adjustments to the difference between the issuer’s error rate and the statistically meaningful value that HHS identifies. We are concerned that if the adjustments are not implemented using this approach, the impact of the adjustment to the risk scores and thus transfer amounts would be unnecessarily significant due to the fact that the adjustment would not account for natural deviation that is expected as part of the RADV results. However, before implementing this policy, Anthem requests that HHS provide more details on how the Agency plans to measure statistical deviations in error rates and allow for issuers to provide feedback and comment.

Anthem recommends that HHS distribute benchmark data so that issuers can assess their performance in relation to the market in the context of this policy. For example, this could include the prior year’s central tendency for the error rate at a national or state level and some measure of distribution. We also
recommend that the summary benchmark data from the prior year RADV include information on general submission rates and medical record retrieval rates.

If HHS does not adopt this proposed approach, Anthem recommends that HHS phase-in the RADV error rate adjustment over time to limit market volatility as RADV moves from its initial pilot stage to full implementation. Phasing in the adjustment would recognize that RADV remains a learning process for both HHS and issuers and that the RADV policy should act to stabilize, not become a destabilizing force in the individual and small group markets.

As part of the RADV process, HHS currently selects a sample of 200 enrollees from each issuer to estimate risk score errors. Anthem recommends that HHS revisit and evaluate whether a sample size of 200 is large enough to estimate risk score error rates, especially for subpopulations. We appreciate the need to keep administrative burdens at a minimum and that increasing the sample size would mean additional work for issuers, auditors, and HHS. However, Anthem would support increasing the sample size if HHS believes that an increase would result in more reliable error rate estimation.

**Rationale:** The RADV process for the individual and small group markets under the Affordable Care Act (ACA) is complex and detailed. As a result, there is an expected margin of error that should be accounted for when determining an issuer’s final error rate and ultimately, any adjustment amount. By not doing so, HHS would effectively be introducing increased volatility into the transfer formula because it would be including this expected deviation. Issuers cannot account for this uncertainty in the transfer formula when developing rates, especially in the initial years when the impact of the potential RADV adjustment is unclear; thus, uncertainty in the transfers as a result of RADV could be considerably destabilizing.

In deciding a methodology for conducting deviation analysis, increasing the accuracy of the analysis must be balanced with preventing the creation of an overly complex program that is both administratively burdensome and difficult to understand. At this time, we do not have access to the detailed data necessary to make an informed recommendation on the most appropriate level at which to conduct the deviation analysis. Thus, we lean on the side of simplicity in the short term and recommend that deviation be measured at the issuer level. Before implementing this policy, Anthem requests that HHS provide more details on how the Agency plans to measure statistical deviations in error rates and allow issuers to provide feedback and comment.

We suggest that HHS study whether doing the deviation analysis at the HCC or group of HCC level increases the accuracy of the RADV process to a degree that warrants implementing a potentially more complex approach. HHS should specifically weigh the benefits of increased accuracy of HCC adjustments against the burden of obtaining statistically valid samples needed to make those adjustments. Additionally, given geographic differences in provider coding and claim submission practices, Anthem recommends that HHS also study whether it is most appropriate to determine the deviation rate at the state or national level.
Anthem supports the HHS proposal and we believe that it would reduce the risk that RADV could generate greater market instability as RADV adjustments begin to be included in the risk adjustment methodology. If HHS opts to finalize a different approach, we strongly recommend that HHS phase-in the adjustment so issuers can gain experience with how the RADV adjustment may impact risk adjustment transfers and ultimately their financial performance.

We also note that there are distinct differences between the Medicare Advantage and the individual/small group risk adjustment programs. These differences have significant implications for the appropriate policies related to RADV error rates and how those should (or should not) be extrapolated from the audit sample to an issuer’s broader enrolled population. Specifically, risk adjustment in the individual and small group markets entails comparing risk scores between issuers, and all issuers participate in the RADV audits each year. This is in contrast with the Medicare Advantage RADV process where not all contracts are subject to yearly audits, and there are not direct, annual comparisons between all Medicare Advantage plans.

**RADV Adjustment Post Issuer Market Exit (153.630)**

**Issue:** The results of the findings of the RADV process will currently be implemented prospectively (i.e., Benefit Year (BY) 17 RADV process impacts the BY18 transfer amounts that occur in the spring of BY19). In the preamble, HHS expresses concern that issuers who have exited the market would not have risk scores or payment transfers in the benefit year in which RADV error rates would be applied and that the prospect of not being subject to payment adjustments based on the RADV results could eliminate exiting issuers’ incentive to carefully and accurately submit EDGE data. HHS therefore proposes that in instances in which an issuer has exited the market, RADV error rate adjustments, as applicable, would apply retrospectively to the benefit year and transfer formula in which the audited data is based on, reallocating adjusted transfer amounts to other issuers in that state in that year.

**Recommendation:** In the situation where an issuer has exited a market, Anthem supports the proposal to use the error rate from the RADV process to adjust the payment transfer for the issuer’s final benefit year in a given state market.

**Rationale:** This proposed approach will help ensure that an issuer who has exited a market and submitted inaccurate data does not benefit from these errors and that other issuers in the market are not harmed by these errors. We do have concerns about the complexities introduced by the potential of retroactive adjustments. To minimize any complexity, Anthem recommends that HHS adopt its proposal discussed above which would limit RADV adjustments to only those instances in which an issuer’s error rate materially deviates from a statistically meaningful value.
Adjustment of Risk Adjustment Transfers Due to the Submission of Incorrect Data (153.630)

Proposal: In certain cases, HHS proposes to make current year transfer adjustments for demographic, enrollment, and premium errors discovered through the RADV process. HHS is proposing to consider these types of errors as a “discrepancy in the transfer process.” The change in the transfer amount would only be made if the difference is detrimental to one or more issuers in the market and the change would increase the liability of the issuer responsible for the error and decrease liability of other issuers in the market.3

Recommendation: Anthem seeks additional clarification related to: (1) the definition of demographic and enrollment data errors; (2) whether errors found in demographic and enrollment data will impact the transfer formula, the risk-adjustment error rate, or both; (3) whether any or all of the components of the transfer formula would be impacted by a change or whether HHS intends to limit which factors would be impacted; and (4) discussion of the timing related to when HHS would typically make changes to the transfer amounts. Specific examples for all four of these areas would help clarify HHS’ proposal. We believe that this additional clarification should be provided, along with an opportunity for stakeholders to comment on the details, before this proposal is finalized.

Rationale: In the preamble, HHS proposes “that demographic or enrollment errors discovered during risk adjustment data validation would be the basis for an adjustment to the applicable benefit year transfer amount, rather than the subsequent benefit year risk score…[A] discrepancy in underlying enrollee diagnosis contributing to risk score… is addressed through subsequent year risk score adjustments as part of risk adjustment validation.” Clarification is first needed on what HHS intends to consider enrollment and demographic errors.

We also have questions regarding how this proposal specifically relates to the RADV process for enrollment and demographic checks and the subsample of 50 enrollees where screen shots are used for verification. In general, Anthem supports HHS’ approach to take a subsample of 50 enrollees to verify enrollment and demographic information. We believe this strikes a good balance between the necessity to verify this information and the operational burdens presented by this labor-intensive process. However, we do not believe that the subsample of 50 enrollees should be the sole basis for applying current year transfer adjustments under this proposed policy for enrollment and demographic errors. If errors are identified from the RADV subsample of 50 enrollees, HHS should then investigate an issuer’s data further to assess if there were materially incorrect EDGE server data submissions. If HHS implements the above proposal, we would recommend that the administrative burden not be increased for all issuers and that

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HHS continue with its existing approach for verifying demographic and enrollee information from a subsample of 50 enrollees.

In addition, depending on the definitions, certain types of enrollment and demographic errors could be impactful to both the transfer formula and to the calculation of an enrollee’s risk score. For example, if an issuer incorrectly attributes a member to a platinum plan, rather than a silver plan, this could be impactful to the transfer formula, but would also have a direct impact on that enrollee’s risk score.

Anthem also seeks clarification as to which components of the transfer formula HHS intends to update based on any errors discovered. It is not clear to us whether HHS intends to limit the impact only to the statewide average premium or expand the impact to other components, such as the allowable rating factor or induced demand factor. For instance, in the example of the incorrectly attributed metal level as previously described, multiple components of the transfer formula could be impacted by such an error. It is unclear on the timing when any such adjustment would be made with respect to the current year risk adjustment transfer amounts and related data errors.

We further note that there are distinct differences between the Medicare Advantage and the individual/small group risk adjustment programs. These differences have significant implications for the appropriate policies related to the adjustment of risk adjustment transfers due to the submission of incorrect data. Risk adjustment in the individual and small group markets is a transfer between carriers, and as a result, material errors in data submissions from one issuer could negatively harm other issuers in a market with an unfair and negative impact on their transfers. Furthermore, all issuers participate in annual RADV audits in the individual and small group markets, whereas a Medicare Advantage contract may not be subject to a RADV audit in a particular year. These differences highlight the need for different RADV and transfer adjustment policies between the commercial and Medicare Advantage risk adjustment programs.

Mental and Behavioral Health Records in the RADV Process (153.630)

Issue: HHS recognizes that certain state and federal privacy rules may restrict providers’ ability to disclose certain mental and behavioral health records. HHS is proposing to amend 153.630(b)(6) to allow for the submission of mental or behavioral health assessment data to serve as a replacement for the associated medical record for risk adjustment validation purposes.

Recommendation: Anthem supports the use of alternative mental or behavioral health assessments from providers to satisfy RADV needs which would not compromise the privacy of consumers and would comply with all federal and state laws regarding mental health and Substance Use Disorders (SUD). We recommend that HHS release guidance on the requirements related to such assessments and how they should be interpreted by an Initial Validation Auditor (IVA).
We recommend that 42 CFR Part 2 be better aligned with the Privacy Rules issued under the Health Insurance Portability and Accountability Act (HIPAA)(45 C.F.R. § 164.500 et seq.) for the purposes of health care treatment, payment, and operations, with appropriate protections.

*Rationale:* Anthem believes allowing the use of these health assessments could help improve RADV. We encourage HHS to communicate with providers on multiple fronts on the need to submit medical records as part of the RADV process and to support the integrity of the overall risk adjustment program. Where there may be barriers to submitting mental and behavioral health records, clear communication to providers regarding the need for submitting health assessments and how they comply with privacy laws would help the overall RADV process. However, we do have concerns that different IVAs may interpret assessment data differently, resulting in inconsistent application across issuers. We recommend that HHS provide guidance and training for IVAs to ensure that this requirement is interpreted and applied consistently across all issuers.

Separately, we note that the federal regulations governing the confidentiality of drug and alcohol treatment and prevention records (42 CFR Part 2) are outdated and incompatible with the way health care is delivered today. These requirements limit the use and disclosure of patients’ SUD records among treating providers and effectively separate SUD treatment records from records regarding physical health. The 42 CFR Part 2 rules have limited providers’ ability to integrate mental health, substance use, and physical health care treatment for patients. 42 CFR Part 2 should be aligned with HIPAA (45 C.F.R. § 164.500 et seq.) for the purposes of health care treatment, payment, and operations, with appropriate protections.

**RADV Materiality Threshold**

*Issue:* In the 2018 NBPP, HHS implemented a RADV materiality threshold for those issuers with total annual premiums ≤ $15M. Qualifying issuers would only be required to conduct an initial validation audit approximately once every three years. Since BY16 was converted into another pilot year, HHS is proposing to delay implementing the materiality threshold until BY18.

*Recommendation:* Anthem opposes establishing a materiality threshold that would exempt qualifying issuers from conducting RADV each year.

*Rationale:* We appreciate the burdens associated with RADV, but believe it is important that all issuers be subject to the same requirements and operate on a level playing field to maintain integrity of the risk adjustment program. Since all issuers are part of the payment transfer calculation, all issuers should participate in annual RADV to ensure they are submitting quality risk adjustment data. This will ensure that all issuers participating in risk adjustment have audited results, which will promote confidence in the risk adjustment program.
Risk Adjustment White Paper Process

**Issue:** In 2016, HHS engaged stakeholders in a thoughtful and open dialogue regarding longer-term improvements to the risk adjustment methodology. This included important improvements such as partial-year enrollment and the limited use of prescription drugs in the model. HHS produced a detailed white paper outlining several open areas for improvement including potential pros and cons for different proposals that HHS was considering. HHS then invited stakeholders to provide comments on the white paper and hosted an in-person meeting to discuss as a group.

**Recommendation:** Anthem recommends that HHS replicate this white paper approach in the spring of 2018 to explore other key proposals for improving the risk adjustment methodology, RADV, and overall program approach. Examples of issues Anthem believes could be addressed in this process include:

- Analyzing enrollee-level EDGE data to study key differences between the individual and small group markets including costs, utilization patterns, induced demand, and partial year enrollment. This could include analyses and dialogue regarding whether different coefficients should be used for the individual versus small group markets.

- Assessing whether RADV error adjustments should be made at the Health Insurance Oversight System (HIOS) ID level or at the HCC or group of HCCs level, and what the impact may be for different approaches;

- Providing more detail on how the Agency plans to measure statistical deviations in error rates at the HIOS ID level and allow for issuers to provide feedback and comment;

- Analyzing and discussing whether additional RXCs should be added or removed from the model. For example, RXC 03 (Antiarrhythmics) and RXC 04 (Phosphate Binders) have relatively low coefficients where the majority of health care spending is on the medical benefit. These two drug categories might be candidates for elimination since there is minimal incremental predicted risk and the diagnoses are almost always captured via medical spending. Two drug classes that Anthem would propose for consideration to add to the model would be growth hormones and antipsoriatics. Given the amount of pharmacy benefit spending for individuals with conditions treated by these drugs, we believe these two RXCs could add meaningful value to the overall model accuracy; and,

- Evaluating whether HHS should move to MedID for a drug classification system instead of RXNorm Concept Unique Identifier (RXCUI). Potential benefits for moving to MedID would be improved stability, accessibility, and predictability. Acquiring RxCUI mapping and keeping it up to date has been a historical challenge. Anticipating changes to RxCUI when submitting
formularies has required educated guesses on the part of issuers and opens the door for missing required drug counts.

*Rationale:* The white paper approach allows for constructive and transparent dialogue and exchange of ideas on how to improve the risk adjustment methodology, RADV and other aspects of the program. This approach, timing, and overall format also complements and helps to inform HHS’ annual risk adjustment rulemaking.


**Applicability to Student Health Insurance Plans (§ 154.103)**

*Issue:* HHS proposes to exempt student health insurance from rate review beginning on or after January 1, 2019. States would have the flexibility to review student health insurance rate increases, and in states without an Effective Rate Review Program, HHS would monitor compliance. HHS would review form filings in states where they are enforcing market reforms.

*Recommendation:* Anthem supports this change.

*Rationale:* We believe that states will be the most effective regulators of rates for these products and can best determine the reasonableness of increases.

**Rate Increases Subject to Review (§ 154.200)**

*Issue:* Single risk pool rates are currently subject to a reasonableness review if the average weighted rate increase exceeds 10 percent or exceeds an approved state-specific threshold. HHS is proposing to increase this federal threshold to 15 percent. Under existing rules, all deviations from the federally-defined threshold must be approved, but HHS proposes to require states to submit proposals for state-specific thresholds, if the proposed threshold is higher than the federal default threshold.

*Recommendation:* We support the recommendation to increase the default threshold to 15 percent, but we recommend that the threshold be applied at the product level instead of the plan level. We further recommend that HHS apply a 15 percent threshold for any *product* or a 20 percent threshold for any *plan*. In addition, we support HHS’ associated proposed change that states would only be required to submit proposals for state-specific thresholds, if the proposed threshold is higher than the federal default threshold.
**Rationale:** The 2016 NBPP required the threshold to be applied at the plan level instead of the product level. Rates at the plan level naturally vary due to common market factors, and reviewing an entire product based on the increase for a single plan is superfluous. Moreover, this proposal encroaches upon state processes and does not increase consumer protections. If HHS finalizes this proposal and applies the threshold at the plan level, we do not believe 15 percent is the appropriate review threshold. We expect that even a plan level threshold of 15 percent would result in a large number of reviews that ultimately find the proposed increases to be not unreasonable.

**Qualified Health Plan vs. Non-Qualified Health Plan Rate Submission Timeline (§ 154.220)**

**Issue:** HHS proposes to interpret §154.220(b) to allow a state with an effective rate review program to set different submission deadlines for rate filings from issuers that only offer non-Qualified Health Plans (QHPs). Issuers that offer both QHPs and non-QHPs would be required to meet the deadline for QHPs.

**Recommendation:** We agree that issuers offering only non-QHPs should be permitted to file later than issuers offering both QHPs and non-QHPs.

**Rationale:** Requiring QHP and non-QHP submissions at a uniform time places an administrative burden on state regulators. A later submission deadline for issuers that only offer non-QHPs allows regulators to complete the review of QHP rate filings in a timely manner. This change would give states the flexibility to pick the timeframe that works best for their markets.

**Posting of Rate Increases (§ 154.301)**

**Issue:** Under existing regulations, states must notify HHS no later than 30 days in advance of making rate increases public. HHS proposes to reduce this notification timeframe down to no less than 5 business days in advance of such postings. HHS also proposes to eliminate the requirement for uniform rate increase posting in §154.301(b)(3) to allow for rates to be posted on a rolling basis rather than at a uniform time.

**Recommendation:** Anthem recommends maintaining the current requirement that rate increase information must be made available to the public at a uniform time.

**Rationale:** The uniform posting requirement for on-exchange and off-exchange filings protects issuers offering exchange coverage in states with rolling deadlines from shadow pricing by competitors not offering on-exchange coverage. In many states, issuers are allowed to make changes during the rate review process, and an off-exchange issuer could gain an advantage if their competitors’ rates become public before the off-exchange issuers’ rates. The uniform posting requirement ensures a level playing field for all issuers and a fair competitive market.
STANDARDIZED OPTIONS (§155.20)

Issue: Starting with the 2017 NBPP, HHS has annually finalized specifications for optional standardized plans to be sold through the Federally-Facilitated Exchange (FFE) and has preferentially displayed these plans on HealthCare.gov. Citing concerns about the impact of standardized plans on issuer innovation and enrollment into other plans or products, HHS proposes not to establish standardized plans for the 2019 plan year. HHS also will not differentially display any plan designs or require agents, brokers, or issuers to provide differential display on their web sites.

Recommendation: Anthem supports HHS’ decision to discontinue standardized plan options in 2019 and recommends that HHS finalize this provision as proposed.

Rationale: Anthem has consistently opposed standardized options as unnecessary and misleading for consumers. EHB-benchmark plan and actuarial value requirements already provide a measure of standardization and comparability across exchange products. In addition, many exchanges, including HealthCare.gov, have implemented sort and filter tools that allow consumers to compare plans based on formulary and network inclusion – achieving some of the stated goals of developing standardized plans. Standardized benefit designs also threaten to commoditize insurance and stifle innovation, while confusing consumers by representing as equivalent those plan options that have meaningful differences, such as formulary coverage and network. Discontinuing standardized plans will allow issuers to focus on developing high-quality, affordable plans that meet enrollees’ preferred level of coverage.

FLEXIBILITY FOR STATE-BASED EXCHANGES AND STATE-BASED EXCHANGES USING THE FEDERAL PLATFORM (§155.106 AND §155.200)

Issue: HHS proposes to explore strategies to make the State-Based Exchange (SBE) using the Federal Platform (SBE-FP) model more appealing and viable to states with FFES and to support retention of existing SBE-FPs. Specifically, HHS seeks to explore options for streamlining current requirements and leveraging private sector and federal platform technologies to increase opportunities for states interested in remaining or becoming SBE-FPs. HHS also seeks feedback on how it can best support the efforts of SBEs to utilize commercial platform services, including technical support and/or regulatory changes that would facilitate use of those services.

Recommendation: Anthem supports HHS’ proposals to streamline current requirements for establishing and maintaining SBEs and SBE-FPs and to facilitate states’ use of private sector and federal platform technologies. To allow states to leverage these technologies most efficiently, we recommend that HHS continue to utilize FFE data collection and submission processes, including standard HealthCare.gov templates to streamline the loading of data onto HealthCare.gov.
Rationale: Anthem believes that states are best positioned to understand the unique needs of their citizens and insurance markets, and to design and implement market solutions for their states. To date, the rigid federal criteria and costs associated with building necessary infrastructure have deterred some states from implementing an SBE or SBE-FP. Affording states the ability to leverage existing commercial and federal platform services will allow them to tailor exchange processes to best meet the needs of their markets.

STANDARDS FOR THIRD-PARTY ENTITIES TO PERFORM AUDITS OF AGENTS, BROKERS, AND ISSUERS PARTICIPATING IN DIRECT ENROLLMENT (§155.221)

Issue: HHS proposes to require agents, brokers, and issuers with direct enrollment platforms to select third-party entities to conduct operational readiness reviews and audits related to the use of the direct enrollment pathway; pre-approval from HHS will no longer be required. HHS also indicates that it will release standards for and develop a training program that review organizations must complete prior to conducting reviews.

Recommendation: Anthem urges HHS to retain its role in approving third-party entities to perform operational readiness reviews and audits.

Rationale: HHS direct enrollment standards are complex, and while issuers have established procedures to ensure third-party vendor compliance with general privacy and security standards, issuers are not equipped to ensure compliance with complicated and sometimes ambiguous federal standards for direct enrollment. Shifting the responsibility for selecting these third-party vendors to issuers and other direct enrollment partners (agents and brokers), particularly during the implementation of enhanced direct enrollment, increases operational and legal burdens on issuers, discouraging their adoption of direct enrollment.

We appreciate HHS’ commitment to reducing federal oversight, particularly when it increases costs for consumers by compounding the regulatory schemes with which issuers must comply. However, since the direct enrollment program affords issuers, agents, and brokers access to sensitive consumer data through the Federal Data Services Hub, and because eligibility determinations are the responsibility of the federal government, HHS should continue to review and approve entities authorized to handle such information. In addition, HHS already has compiled a list of auditors approved to conduct direct enrollment operational readiness reviews. The ability of issuers to select and rely on entities pre-approved by HHS should help to smooth the launch of direct enrollment, both for issuers and the federal government.
Verification Process for Determining Eligibility for Insurance Affordability Programs – Income Inconsistencies (§ 155.320)

**Issue:** HHS proposes that the exchange generate annual income inconsistencies for tax-filer circumstances when a tax-filer’s attested projected annual income is greater than the income amount represented by income data returned by the IRS, Social Security Administration, and other trusted data sources. This proposal applies only to tax-filers for whom the trusted data sources report income below 100 percent of the federal poverty level.

**Recommendation:** Anthem opposes the proposal to generate an annual income inconsistency for this low-income population.

**Rationale:** Currently, HHS generates an annual income inconsistency only if a tax-filer’s projected annual income is lower than the amount reported by the Agency’s trusted data sources. Exchanges are not permitted to create inconsistencies when the consumer’s attested income is greater than the amount represented by income data returned by trusted data sources. Anthem is concerned that it may be difficult for individuals to provide documentation of an actual or anticipated increase in income and that this additional administrative burden may discourage healthy individuals from completing their enrollment. If these individuals reside in a state that did not expand Medicaid and cannot demonstrate why their income is inconsistent with trusted data sources, they may be left without any source of affordable coverage.

Annual Eligibility Redetermination (§ 155.335)

**Issue:** Currently, enrollees may authorize exchanges to access their IRS tax return information for up to five years. HHS seeks comment on whether reducing the authorization period would improve exchange program integrity.

**Recommendation:** Anthem recommends that HHS continue to allow enrollees to authorize exchange access to tax return information for up to five years.

**Rationale:** Anthem appreciates the importance of obtaining accurate, up-to-date eligibility information from enrollees. We are concerned, however, that enrollees who are confused or unaware of the change to the authorization rules are unlikely to complete a reauthorization, resulting in a termination of their Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSRs) unless they actively re-enroll in coverage. While the change may prompt some enrollees to return to the exchanges to update their
information, we believe it more likely that individuals will not update their information, lose their APTC and CSRs, and be unable to afford coverage.

We also expect that the confusion generated by the proposed change to the reauthorization period will add to issuers’ administrative burden by increasing call center volume and requiring additional enrollee communications. To that point, the current online and paper exchange application clearly explains the 5-year authorization and allows the consumer to select a shorter authorization period. We further believe that the current enrollment process affords consumers sufficient opportunity to update their eligibility information and adequately balances the exchanges’ need for accurate information with the interest of ensuring that consumers have access to affordable coverage.

Program Integrity (Preamble)

**Issue:** In the preamble to the proposed rule, HHS indicates its intent to issue future rulemaking and guidance addressing exchange program integrity issues, including exchange processes for matching enrollment data with Medicare and Medicaid. HHS requests comment on its specific proposals as well as feedback on other ways to ensure that only those individuals eligible for exchange coverage receive such coverage and to “safeguard the federal tax dollars flowing through [e]xchanges.”

**Recommendation 1:**

Anthem supports HHS’ proposal to streamline coverage coordination with public programs by implementing exchange processes for matching enrollment data with Medicare and Medicaid, and further recommends that HHS extend these processes to the Children’s Health Insurance Program (CHIP). We also urge HHS to make the FFE responsible for preventing individuals from dually enrolling in a public program and QHPs at the time of initial application and at renewal.

**Rationale:** Anthem believes that those eligible for Medicare, Medicaid, or CHIP should enroll in such programs and transition off individual commercial coverage. Those public programs are specifically designed to reflect the health, cost-sharing, and other needs of their eligible populations. The enrollment of such individuals in QHPs increases the cost of individual health insurance as well as the amount of APTCs paid by the federal government. In addition, individuals who are eligible for Medicare but enrolled in a QHP may face delayed coverage start dates and enrollment penalties when untimely transitioning to Medicare coverage.

**Recommendation 2:**

Anthem urges HHS to re-issue the 2016 Interim Final Rule (IFR) on End-Stage Renal Disease Third Party Payments (CMS-3337-IFC) as a Proposed Rule and finalize it as soon as possible. The IFR would have imposed additional disclosure requirements on Medicare-certified dialysis facilities that make premium
payments either directly through a parent organization, or through a third party, broadening it to prevent health care providers, manufacturers, or the interest groups and foundations that they support from steering individuals who are eligible for Medicare and Medicaid to private coverage. We also recommend that HHS prohibit exchange assisters and application counselors from inappropriately steering individuals who are eligible for coverage under a public program to the individual market.

*Rationale:* It is critical to maintain a balanced risk pool to ensure coverage is affordable across the entire market under the ACA requirements for guaranteed issue and community rating. The steering of individuals from Medicare and Medicaid into the individual health insurance market by third parties in an effort to increase their reimbursements results in deterioration of the risk pool. This leads to increased premiums across the market which then leads to an increase in the amount of federal spending on subsidies. Reissuing the IFR and expanding it to exchange assisters and application counselors will help to ensure that individuals are not steered away from public programs based on a third party’s financial interests rather than the interests of the enrollee and will protect the broader population in the private market.

Anthem appreciates CMS’ attention to the impact that steerage of Medicare and Medicaid beneficiaries into the individual market and improper third-party payments are having on the individual market risk pool. We agree with CMS that third-party premium payers should not direct Medicare and Medicaid eligible consumers to enroll in individual market coverage. This is especially true when that enrollment is driven by third parties who may be motivated primarily by higher reimbursement rates in the commercial health insurance market and not by the most advantageous coverage for the long-term health and well-being of the consumer. Consumers receiving third-party premium payments may not be adequately advised that those payments are tied to a particular treatment program or receipt of specific services, such as dialysis. If the payment assistance ends mid-year, (e.g., after an individual finishes a substance abuse program or receives an organ transplant), consumers may not be able to afford the full premium, preventing them from accessing continuous coverage for the remainder of the year.

*Recommendation 3:*

Current regulatory requirements that limit when issuers may communicate rate and benefit information to enrollees and restrict the format and content of such communications prevent issuers from providing enrollees with the information necessary to make benefit coverage decisions in a timely manner.

Anthem recommends that HHS revise existing rules to afford issuers greater flexibility to provide enrollees with critical information regarding their choices related to renewal and discontinuation in an understandable format as early as is practicable during the open enrollment process to ensure that they are adequately informed about their future coverage options. For example, we urge HHS to allow issuers to include in discontinuation notices an explanation that the enrollee will be automatically renewed into another plan and that further details of that plan will be provided in a subsequent communication.
Rationale: Anthem has extensive experience with member communications, and we strive to ensure that such communications are not only both clear and concise, but written at an appropriate reading level for the population we serve. Anthem appreciates HHS’ interest in promoting consistency among consumer-facing materials. However, it is critical that renewal and discontinuation notices contain certain issuer-specific information, including, but not limited to, benefits (e.g., provider network and formulary information), premiums, APTC, and cost-sharing obligations, as well as instructions on how consumers can update their eligibility information. Enrollees must have such information to make informed, timely decisions regarding their coverage. The limitations presented by the standard HHS notices make it difficult for issuers to tailor information so that it is useful and understandable to enrollees. The language required to be used in the standard notices has resulted in consumer confusion in the past. In addition, allowing issuers to develop and produce their own notices rather than waiting to prepare notices after HHS has issued the prescribed forms will help issuers to streamline and expedite their notification processes, thus giving enrollees more time to evaluate their coverage options.

SPECIAL ENROLLMENT PERIODS (§155.420)

Plan Options under Select Special Enrollment Periods (§§155.420(a)(i), 155.402(a)(iii))

Issue: HHS proposes to standardize the treatment of Special Enrollment Period (SEP) eligibility and coverage start date options for all eligible dependents – whether they are new or existing dependents of those currently enrolled.

Recommendation: Anthem supports consistent treatment of all dependents regardless of the SEP under which they qualify and regardless of whether the enrollment is on- or off-exchange. We recommend, however, that HHS clarify that in the case of a newborn or adopted child, SEP eligibility only extends to the new household member and that such eligibility only allows for enrollment of the child either in the same plan in which the other members of the household are already enrolled or into a child-only policy.

Rationale: Ensuring consistent treatment of dependent SEP eligibility and coverage start date options will reduce enrollee confusion and simplify the process for enrollees, issuers, and HHS. Streamlining processes across markets will also promote continuity of coverage and increase the likelihood that family groups can remain enrolled together.

Anthem agrees that it is important for newborn or adopted children to be able to enroll in the coverage in which the other members of the household are currently enrolled or to enroll in a child-only policy. However, to allow the remaining members of the household to change coverage level due to the SEP for the child would create opportunities for adverse selection.
Plan Changes within the SEP Correction Window

Issue: Individuals are taking advantage of the flexible coverage effective dates available to them under SEPs to enroll in a higher metal level plan retroactively and subsequently switch to a lower metal level plan prospectively.

Recommendation: Anthem recommends that HHS modify current SEP regulations to prohibit individuals from making plan changes during their window of eligibility for an SEP.

Rationale: Issuers continue to see families take advantage of the effective date flexibility for SEPs, particularly for newborns and other retroactive SEPs. Some families select a higher metal level plan that covers delivery and neonatal care at low cost-sharing levels, and then use the flexibility within their 60-day SEP window to change to a bronze plan for the remainder of the year. This misuse of the flexibility for selecting effective dates for SEPs encourages adverse selection and ultimately increases premiums for higher metal-level plans.

Exception to Prior Coverage Requirement Living in Service Areas Where No QHP is Available On-Exchange

Issue: HHS proposes to exempt consumers who previously lived in a service area that did not have any exchange options from the previous coverage requirements.

Recommendation: Anthem urges HHS to ensure, through thorough pre-enrollment eligibility verification, that the enrollee has experienced a legitimate permanent move within the previous 60 days and to require documentation of the qualifying event. We further recommend that HHS publish a list of service areas in which no QHPs are offered to ensure the consistent application of this policy both on- and off-exchange.

Rationale: Anthem recognizes that SEPs provide necessary access to health insurance coverage for eligible individuals with valid qualifying events. As we have expressed in prior comments and elsewhere in this letter, we appreciate HHS’ recent focus on SEPs and adverse selection, and we support the Agency’s efforts to balance access to coverage with appropriate eligibility verification. We remain concerned, however, that even with these changes, the regulations in force do not sufficiently prevent improper use of SEPs to access coverage outside of the open enrollment period, particularly in the case of the SEPs for marriage and permanent move. Some issuers have noticed that some individuals who have not made a permanent move – such as those being released from a residential treatment facility or from a very short period of legal confinement (often as short as a day) – are inappropriately gaining access to SEPs. While Anthem commends HHS for implementing a pre-enrollment verification process in the FFM, we believe that it is important that HHS continue to take actions to ensure that only those who are eligible gain access to SEPs.
EFFECTIVE DATES FOR TERMINATIONS (§155.430)

Issue: HHS proposes to eliminate the 14-day notification period required for terminations and to allow enrollees to request prospective or same-day termination. HHS seeks comment on whether issuers are able to effectuate same-day terminations and whether the proposed change should be optional for exchanges or issuers.

Recommendation: We support HHS’ proposal to allow enrollees to request effective dates for termination that more closely align with the date of request. Current exchange operations, however, do not allow for effectuation of same-day termination, as the exchange does not transmit the 834 transaction specifying the effective date of termination until after 6:00pm EST on the day on which the termination request is made. As it then takes issuers another day to process the request, we recommend that issuers be afforded at least two calendar days from the date of request to effectuate the termination.

Rationale: Anthem agrees with HHS that more closely aligning the effective date of termination of coverage with the date of request will help to streamline and simplify the termination process for consumers. Given the constraints of the current exchange process for transmitting 834 transactions and the time required for issuers to process a termination request, two calendar days following the date of request is the earliest that issuers can effectuate a termination.

ESSENTIAL HEALTH BENEFITS (§§ 156.100, 156.111, 156.115)

Additional State Benchmark Plan Options

Issue: HHS proposes to allow states to select a new EHB-benchmark plan annually, and to provide additional options from which states can select their benchmark plans. Beginning in 2018 for the 2019 plan year, states could change their 2017 EHB-benchmark plan by: 1) choosing a 2017 benchmark plan from another state; 2) replacing one or more EHB categories of benefits in its 2017 EHB-benchmark plan with the same category of benefits from another state’s 2017 benchmark plan; or 3) selecting a set of benefits that would become the EHB-benchmark plan and is equal in scope to a typical employer plan without being more generous than the most generous of a set of comparison plans.

Recommendation: While Anthem supports HHS’ goal of affording states greater flexibility to regulate their markets, including defining EHB, we oppose the current proposal to provide additional options from which states can choose to update their EHB-benchmark plans on an annual basis.

Rationale: Anthem agrees with HHS that states should have greater flexibility to modify EHB in an effort to offer consumers more affordable coverage better suited to their health care needs. In the preamble to the proposed rule, HHS discusses how states may modify their EHB-benchmark plans to reduce the costs
of benefits. The options from which states select their benchmarks, however, do not differ significantly with respect to their core benefits. The most significant differences among state EHB-benchmark plans are driven primarily by state mandated benefits, which limit states’ ability to change their benchmark plans to reduce the cost of coverage. Current EHB requirements ensure that plans provide a robust package of benefits that meet the full spectrum of consumers’ health care needs. We are concerned, however, that states may utilize the proposed EHB-benchmark selection process to further expand these benefits packages, without defraying the costs, resulting in higher premiums, deductibles, and cost-sharing, ultimately making plans less affordable for consumers.

Anthem also believes that the lack of predictability that would come with annual updates to EHB-benchmark plans will result in confusion for consumers who have come to rely on some consistency among plan benefit packages from year to year.

Annual Selection of State Benchmark Plans

Issue: HHS proposes to allow states to select new EHB-benchmark plans annually. For the 2019 and 2020 plan years, HHS proposes that states submit documentation of their benchmark plan selections by March 16, 2018 and by July 1, 2018, respectively. Due to the short timeframe for 2019, HHS would not be able to update the Plans and Benefits Template Add-in file for 2019.

Recommendation: Given that issuers have already begun developing products for the 2019 benefit year, the proposed timeline for the 2019 benefit year is unworkable for states and issuers. Allowing for the submission of benchmark plans as late as March 16, 2018 will not provide sufficient time for states to review benchmark plan selections, collect public feedback, or approve benchmark plans in time for the 2019 QHP certification and rate review processes.

If HHS proceeds with the proposal to allow states to select from additional EHB-benchmark plans/benchmark plan categories, Anthem urges HHS to maintain the current rule that permits a change in benchmark plan only every three years, and to ensure that the timeline for submission and approval of new benchmark plans occurs at least 18 months prior to the beginning of the applicable plan year.

Rationale: Issuers understand the importance of offering high-quality insurance plans at affordable prices. Toward that end, we are continually working to develop a diverse selection of plan options that meet both the financial and health care coverage needs of our consumers.

Requiring issuers to modify products as often as annually to reflect changes to EHB-benchmark plans will disrupt the product development and pricing processes. We also are concerned that the substantial operational and systems changes that would be required to accommodate annual updates to EHB-benchmark plans, such as changes to member-facing plan documents and claims processes, will require issuers to divert resources from other critical functions, such as the development of more innovative
benefit designs and improvements to customer service.

Defrayal of Additional Costs

**Issue:** HHS requests comments on application of the current state mandate policy under the proposal to provide states additional options from which to select their benchmark plans, including input on whether a different approach should be taken to defray the costs of any benefits mandated by state action.

**Recommendation:** If HHS proceeds with the proposal to allow states to select among different EHB-benchmark plans/benchmark plan categories, Anthem urges HHS to adopt requirements that would ensure that states defray the costs of additional benefits that must be covered as the result of the selection of a new EHB-benchmark plan or substitution of an EHB benefit category, regardless whether the state mandates provision of the additional benefits by statute.

**Rationale:** Current rules require states to defray the costs of any benefits mandated by state action taken after December 31, 2011. These rules, however, effectively allow states to expand benefits without defraying additional costs under certain circumstances (e.g., increasing age/quantity limits, requiring coverage of a benefit unless the cost exceeds a certain percentage of premium). While Anthem recognizes that HHS’ benchmark plan proposal is intended to afford states the opportunity to modify EHB to increase the affordability of coverage in their marketplaces, we are concerned that some states may utilize the new process to expand coverage without actually mandating any new benefits, thereby avoiding the requirement to defray the additional costs of such benefits.

Default Federal Benchmark Plan

**Issue:** For future years, HHS is considering establishing a federal default definition of EHB aimed at better aligning medical risk in insurance products by balancing costs to scope of benefits. The Agency seeks comment on this proposal, particularly with regards to the establishment of a federal prescription drug benefit standard as part of the federal EHB default definition.

**Recommendation:** While Anthem recognizes there could be potential benefits to a federal prescription drug standard, we believe this proposal warrants further exploration through additional proposed rulemaking with opportunity to comment. Any federal standard should include guardrails that allow plans the option to provide additional formulary choice beyond the logical constraints established by HHS. The intent of such a proposal should not be to establish a broad, single national formulary, but to ensure that the new formulary serves as a national benefit standard floor for states that opt to adopt their own EHB benchmarks.

**Rationale:** Affording issuers and pharmacy benefit managers the opportunity to develop a national formulary may allow them to more effectively negotiate with prescription drug companies which will lead
to more affordable coverage for consumers. We would encourage HHS, however, to afford health plans discretion within individual state markets to 1) expand their formulary options beyond this new federally-permitted floor; and 2) utilize reasonable medical management techniques to favor preferred drugs within similar specialties or condition-specific classes within the new confines. This hybrid approach would afford issuers greater flexibility, resulting in enhanced consumer plan selection options as issuers continue to develop and improve VBID principles.

Public Posting of State EHB-Benchmark Plan Selections

*Issue:* HHS proposes that states be required to publicly post and provide the opportunity to comment on their EHB-benchmark plan selections.

*Recommendation:* Anthem supports HHS’ proposal to require states to publicly post and provide the opportunity to comments on their EHB-benchmark plan selections.

*Rationale:* Public posting of states’ EHB-benchmark plan selections promotes transparency which benefits not only consumers, but issuers who must ensure that their plans cover the benefits offered under the EHB-benchmark plan. If HHS proceeds with the proposal to allow states to select benchmark plans and/or substitute benefit categories from other state categories, it will be even more critical for issuers and consumers to have access to detailed information on all states’ EHB-benchmark plans.

Draft Example of an Acceptable Methodology for Comparing Benefits of a State’s EHB-Benchmark Plan Selection to the Benefits of a Typical Employer Plan

*Issue:* If a state opts to select a new EHB-benchmark plan utilizing the proposed options 2) or 3) described above (page 27), the state would be required to submit an actuarial certification that affirms that the state’s EHB-benchmark plan is equal in scope to benefits provided under a typical employer plan. In addition, if the state selects a new EHB-benchmark plan using the proposed option 3), the actuarial certification would also be required to affirm that the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans. In a separate document, the Draft Example, HHS provides one example of an approach that actuaries might follow when comparing benefits in order to complete the required actuarial certification to affirm that the equal-in-scope-and-generosity requirements are met. HHS seeks comment on the Draft Example methodology, including any clarifications that are needed.

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4 Option 2 is replacing one or more EHB categories of benefits in its 2017 EHB-benchmark plan with the same category of benefits from another state’s 2017 benchmark plan. Option 3 is selecting a set of benefits that would become the EHB-benchmark plan and is equal in scope to a typical employer plan without being more generous than the most generous of a set of comparison plans.
The three steps outlined in the Draft Example methodology are as follows:

1. **Select the “Typical Employer Plan.”** HHS proposes to define a “Typical Employer Plan” as an employer plan within a product with at least 5,000 enrollees sold in the small group or large group market, in one or more states; or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states.

2. **Using reasonable actuarial assumptions, calculate the expected value of covering all of the benefits at 100 percent value in the “Typical Employer Plan.”** HHS suggests that an enrollment-weighted average of index rates from the state’s small group market could be used to calculate the expected value.

3. **Compare the expected value of covering all of the benefits (at 100 percent value) in the “Typical Employer Plan” to the state’s proposed EHB-benchmark plan.** The comparison should also demonstrate that each applicable category of benefits in the “Typical Employer Plan” is equal to those same categories in the state’s EHB-benchmark plan. To satisfy this test, the state’s actuary can demonstrate that each EHB category contained in the “Typical Employer Plan” has an expected value of at least 98 percent of the state’s EHB-benchmark plan using appropriate actuarial assumptions and methods.

**Recommendation:** Anthem supports the proposal to define a “Typical Employer Plan” (typical plan) as an employer plan with at least 5,000 enrollees in the small group or large group market in one or more states. We do not, however, support the proposal to define the typical plan as a self-insured group health plan.

In the example above, HHS proposes that the state’s actuary could demonstrate that the EHB-benchmark plan has benefits that are equal in scope to the typical plan by showing that each EHB category in the typical plan has an expected value of at least 98 percent of the EHB-benchmark plan. We recommend that HHS propose that states could demonstrate that the benefits in the two plans are equal in scope if the benefits in the typical plan are at least 98 percent, but no more than 102 percent, of the state’s EHB-benchmark plan. Furthermore, this threshold should be applied at the EHB category level and the plan level.

**Rationale:** We agree that it is appropriate to define a typical plan as a small group or large group plan with at least 5,000 enrollees in one or more states; however, self-insured plans are customized to the members within the plan and should not be considered typical. As HHS notes in the preamble discussion, another challenge in using a self-insured plan is that there is no publicly available information for self-insured plans that a state could use for development of a benchmark.

We recognize that some mechanism is needed to assist states in complying with the requirement to choose an EHB-benchmark plan that has benefits that are equal in scope to the benefits of a typical plan. The use
of an enrollment-weighted average of index rates, however, is not appropriate for this comparison since the index rate is issuer-specific and applies to multiple plans within a product. We encourage HHS to find a more appropriate measurement of average charges, such as the average allowed charges for the state’s typical plan. In addition, it would be challenging for states to demonstrate that benefits within each EHB category are equal in scope between the EHB-benchmark plan and the typical plan. Benefit relativity tools used by issuers, regulators, and employers are not able to accurately compare benefits within categories and are typically used to compare benefits in aggregate. Therefore, we recommend that HHS seek additional input from subject matter experts on an appropriate method for comparing benefits that does not rely on the use of index rates.

We believe it is HHS’ intent to provide an example of a methodology that could be used to demonstrate that a state’s benchmark plan benefits are equal to benefits provided under a typical plan in the state. As written in the HHS Draft Example above, the methodology could not be used to prove equality between the two plans. The proposed methodology would only demonstrate that the typical plan has benefits that are equal to or greater than the state’s EHB-benchmark plan. In fact, using the methodology above, a state’s EHB-benchmark plan could have an expected value that is well below the typical plan. We recommend that HHS clarify that, in the Draft Example above, the state’s actuary should demonstrate that the benefits under the typical plan have an expected value that is between 98 percent and 102 percent of the expected value of benefits under the state’s EHB-benchmark plan.

**Benefit Substitution**

**Issue:** HHS proposes to expand the current rule allowing benefit substitution within EHB categories to allow substitution of benefits across EHB benefit categories, provided that the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit.

**Recommendation:** Anthem opposes the proposal to allow issuers to substitute benefits across EHB benefit categories. If HHS proceeds with the proposal, we urge HHS to require that states publicly post and allow the opportunity for comment on issuer requests for substitution.

**Rationale:** Ensuring a level playing field among issuers is critical to competition and marketplace stability. While Anthem appreciates HHS’ efforts to afford issuers greater flexibility with respect to benefit design, we are concerned that allowing substitution of benefits across EHB categories could lead to gaming by some issuers that ultimately harms consumers. For example, issuers might design products that are unattractive to higher-cost populations and/or not adequately reimbursed by risk adjustment.

We also are concerned that benefit substitution may lead to confusion for consumers as a lack of uniformity will make it more difficult for consumers to make meaningful comparisons among plans. In addition, a lack of uniformity among plans would likely increase the administrative burden of issuers and states as it will become more difficult for issuers to conform plans to filing templates.
Rather than allowing for benefit substitution, we suggest that HHS extend greater flexibility to issuers with respect to their use of VBID within the individual and small group markets and use of innovative cost-sharing strategies to incentivize more cost-effective enrollee behavior and higher quality health outcomes. We are very encouraged by HHS’ recognition of the potential value that these types of benefit plan designs can bring to the market and have provided feedback below in response to HHS’ request for comments on how it can better encourage these types of plan designs, and whether any existing regulatory provisions or practices discourage such designs.

QUALIFIED HEALTH PLAN MINIMUM CERTIFICATION STANDARDS (§156.200, §156.230, §156.235, §156.275, §156.1130)

Reliance on State Oversight

Issue: HHS proposes to continue to further enhance state flexibilities. Specifically, in SBE-FP states that perform plan management functions, HHS proposes to continue to rely on state reviews of benefit design, formulary, network adequacy, and non-discrimination. In FFE states that do not perform plan management functions, HHS proposes to review QHP data, but to rely on state review for licensure, good standing, and network adequacy. HHS also restates its intent to rely on states for identification of rate outliers, except in states that do not have an Effective Rate Review Program. For 2019 and beyond, HHS proposes to expand FFE states’ role in the QHP certification process by relying on states for oversight of accreditation requirements, compliance reviews, minimum geographic area reviews, and quality improvement strategy reporting.

Recommendation: Anthem generally supports HHS’ proposals to defer review of certain QHP certification standards to states, including the determination of applicable standards and thresholds in most situations. We encourage HHS, however, to continue to provide states with a common set of templates and tools to be used in gathering data from issuers.

HHS should share with states federally developed tools, including templates and data accuracy tools, and should eliminate or minimize federal data collection from issuers to the data necessary to populate HealthCare.gov for plan comparison.

Rationale: Anthem appreciates HHS’ recognition of the traditional role of states in overseeing their health insurance markets while reducing the regulatory burden of participating in exchanges for issuers. Most states already have in place the systems necessary to perform many plan management functions and already conduct some of the reviews necessary to determine whether plans are meeting certification standards. The unnecessary duplication of effort between HHS and the states increases administrative burden, which ultimately increases the cost of coverage for enrollees. Elimination of this duplication also
would reduce data errors, positioning states, HHS, and issuers to deliver more accurate, complete, and reliable information to consumers.

Accreditation (§156.275)

**Issue:** HHS proposes to defer to states on matters related to accreditation to the extent feasible and appropriate.

**Recommendation:** Anthem recommends HHS require states that will be conducting the review for accreditation continue HHS’ approach of allowing issuers to choose from any of the accrediting entities recognized by HHS.

**Rationale:** HHS currently allows issuers to choose among several accrediting entities from which to receive accreditation. If HHS allows states to limit those accreditation options, issuers may be required to go through the lengthy and costly process of getting accredited again by a different entity with the same standards.

Quality Improvement Strategy (§156.1130)

**Issue:** HHS proposes deferring to states on matters related to Quality Improvement Strategy (QIS) reporting to the extent feasible and appropriate.

**Recommendation:** While Anthem supports HHS’ deferral to states on matters related to QIS, we urge HHS to continue to have states rely on the federal methodology for the QIS review.

**Rationale:** Allowing states to develop different methodologies for the QIS review would greatly increase the administrative burden on issuers like Anthem who offer plans in multiple states.

FUNCTIONS OF AN EXCHANGE (§§ 156.230, 156.235, 155.200)

**Implementation and Enforcement of Network Adequacy and Essential Community Provider Requirements (§ 156.230)**

**Issue:** HHS proposes to allow SBE-FPs to determine how to implement and enforce network adequacy and Essential Community Provider (ECP) requirements for exchange plans.

**Recommendation:** Anthem supports HHS’ proposal to allow SBE-FP states to determine how to implement and enforce network adequacy and ECP standards. We further recommend that HHS eliminate the 20 percent ECP threshold and defer to the states for their review.
Rationale: The states have a very long history of actively regulating the business of insurance in the U.S. This traditional role was acknowledged when, in 1945, the U.S. Congress passed the McCarran Ferguson Act to ensure that, with respect to the business of insurance, states remained the primary oversight and regulatory authorities.

Anthem firmly believes that states are in the best position to understand the unique needs of their citizens and that most are well-positioned to regulate issuers and evaluate plan networks. States are familiar with consumer needs, provider availability, market dynamics, and patterns of care – all of which are relevant to evaluating the adequacy of a plan’s network. Moreover, accrediting agencies and state organizations regularly assess networks to ensure access to a wide breadth of providers, and have processes for working with health plans to develop appropriate networks.

HHS should further consider eliminating the requirement for health plans to submit the ECP/Network Adequacy template. Currently, FFE and SBE-FP health plans are required to submit the ECP/Network Adequacy template to demonstrate compliance with the 20 percent ECP threshold.

Plans are instructed not to populate the network adequacy portion of the template for states with an adequate network adequacy review process since that review is being conducted by the states. Given that state network adequacy review requirements already include a review of ECPs, states should not be required to submit ECP information to HHS. This reporting requirement creates a fiscal burden for health plans that does not exist in other markets.

Assessment of Compliance with the ECP Requirement (§ 156.235)

Issue: HHS does not propose any changes to its method of assessing compliance with the ECP requirement at the service area level rather than at a network level.

Recommendation: As all in-network ECPs are available to consumers in each service area in a state in which Anthem offers plans, we urge HHS to assess ECP compliance at the network level rather than the service area level.

Rationale: Anthem generally does not believe that the service area is the appropriate threshold for the assessment of ECP compliance. A network includes all ECPs from all service areas plus all contracted providers who do not fall under the ECP banner. As an example, in the 2017 QHP filings for Georgia, network ID GAN003 (Pathway X Enhanced) covers 16 service areas (GAS002 – GAS017) according to the ECP Review Tool report. This means the 30 percent threshold for GAN003 had to be met 16 times – once in each service area. This review is overly burdensome as the network evaluation does not give any consideration to the fact that all ECPs listed for GAN003 are considered in-network for any plans sold in any of those 16 service areas.
Finally, some of the ECP requirements rely on information that is not readily accessible by the issuer. For instance, issuers must rely on providers and hospitals to supply information on hospital beds and Full-Time Employees (FTEs). HHS should not require issuers to submit these data.

Network Breadth Pilot

**Issue:** HHS does not propose any changes to the network breadth pilot nor the network breadth indicator.

**Recommendation:** Anthem recommends that HHS discontinue the network breadth pilot and eliminate the current network breadth indicator.

**Rationale:** While the network breadth pilot has been in a testing phase for several years, there is no evidence to suggest that consumers use this indicator in making coverage decisions. Further, we remain concerned that the indicator itself misleads consumers based on the methods used to categorize network breadth.

Ultimately, consumers want to know whether high-quality providers who are important to them are included in their plan’s network, rather than arbitrary measures of network size. Under HHS’ approach, the designation of a plan’s network as “broad” could imply to a consumer that most providers are included. However, the consumer may later find out that a preferred provider is not in the network. We are particularly concerned about possible mischaracterizations of network breadth for plan networks operating in rural areas, which under the current methodology, may be compared to plan networks operating closer to population centers. Further, the indicator is based on time and distance standards from the Medicare Advantage market, which are not translatable to the exchange population. The indicator also does not include any adjustments for provider quality. For these reasons, we continue to believe that the network breadth pilot and indicator may at worst, hinder, and at best, have no impact on consumers’ ability to select a plan that meets their needs.

Machine-Readable Data Requirement

**Issue:** The requirements to make data available in a machine-readable format are burdensome and the underlying data schema is flawed resulting in false negatives displaying to consumers (e.g. in-network provider groups may show up as out-of-network and vice versa). Further, the data is redundant and creates two sources of truth since the more accurate and current directory information is available directly on each QHP issuers’ website. For these reasons, the provider look-up tool on HealthCare.gov is of marginal value to consumers as problems continue to persist.

**Recommendation:** Anthem recommends HHS suspend the requirement for machine-readable data until it resolves problems that negatively affect the quality, utility, and clarity of the data, and establishes an effective, continuing process for addressing operational problems if the requirement is restored. We also
recommend that requirements for the data in the QHP provider directory align with requirements for non-exchange plans; easing the administrative burdens on health plans.

Rationale: When the data schema was introduced in 2015, data experts commented that the schema needs to be fixed because it does not push the assignment of plan coverage and acceptance of new patients down to a lower level of granularity – yet the schema has changed hardly at all since. Moreover, the provider look-up tool that uses these data continues showing false negatives (e.g., many in-network provider groups show up as out-of-network). Until HHS resolves these problems and the known errors and issues are addressed, using the machine-readable data will potentially mislead many consumers.

OTHER CONSIDERATIONS (Preamble)

Value-Based Insurance Design

Issue: HHS seeks comment on whether and how current regulations or policies should be modified to facilitate access to innovative market-driven strategies that could improve care management, quality, costs, and health outcomes while lowering premiums. HHS is particularly interested in feedback on how it can encourage VBIDs that promote effective drug tiering structures; address overused, higher cost health services; provide innovative network design that incentivizes enrollees to use higher quality care; and promote use of preventive care and wellness services.

Recommendation: To allow and encourage issuers to include VBID features in exchange plans, we recommend that HHS take the initial step of affording issuers flexibility to promote VBID by:

- Allowing issuers to detail a plan’s VBID benefits in SBCs and other enrollee notices; and,

- For all non-grandfathered coverage, including QHPs, establishing that in a two-tier or three-tier network design, only cost-sharing for benefits obtained through the first tier accumulate to the out-of-pocket-maximum.

Rationale: Anthem shares HHS’ commitment to identifying and implementing innovative, cost-effective approaches to plan and benefit design, and to educating enrollees so that they can select the plans that will best meet their health care needs. Allowing for the description of VBID benefits in SBCs and other plan communications will enable issuers to more effectively communicate to consumers with chronic conditions how they might benefit from coverage under these plans.

Promotion of VBID also requires that issuers have additional flexibility to design plans customized to certain conditions and/or enrollee populations and which drive the utilization of high-value services and effective treatments. This flexibility can be in the form of safe harbors from certain non-discrimination
provisions, network standards, out-of-network cost-sharing requirements, formulary benchmarks, or service area standards.

High-Deductible Health Plans and Health Savings Accounts

**Issue:** HHS seeks comment on how to encourage issuers to offer HDHPs that can be paired with HSAs as cost-effective coverage options.

**Recommendation:** Anthem recommends that HHS and the IRS amend existing IRS guidance to afford issuers the flexibility to offer HDHP-HSAs that provide pre-deductible coverage of benefits and services, including medications, related to the management of chronic conditions.

**Rationale:** Current IRS guidance includes a safe harbor that allows HDHPs to provide coverage for preventive services before a consumer meets the plan’s deductible. Expanding the existing safe harbor to include benefits and services related to the management of chronic conditions will allow issuers to incorporate VBID principles into HDHP-HSAs, making these plans more attractive to consumers with chronic conditions, who will then be more likely to take advantage of higher-value treatments and achieve better condition management.

**STAND-ALONE DENTAL PLAN ACTUARIAL VALUE (§ 156.50)**

**Issue:** HHS proposes to remove the Actuarial Value (AV) requirements for Stand-Alone Dental Plans (SADPs) offered through the exchanges.

**Recommendation:** Anthem supports HHS’ proposal to remove the AV requirements for SADPs sold through the exchanges.

**Rationale:** Eliminating the AV requirements for SADPs will allow issuers to offer consumers a greater number of diverse benefit options that will allow them to choose the plan that best fits their unique needs. We encourage HHS to promptly finalize this flexibility to allow issuers time to operationalize these changes as soon as possible.

**FFE AND SBE-FP USER FEE RATES FOR THE 2019 BENEFIT YEAR (§156.50)**

**Issue:** HHS proposes to maintain the 2019 benefit year user fee rate for all participating FFE issuers at 3.5 percent of total monthly premiums. HHS also proposes to raise the user fee for issuers offering QHPs through an SBE-FP from 2 percent to 3 percent of premiums.
Recommendation: Anthem recommends that HHS maintain the current SBE-FP user fee of 2 percent. We also urge HHS to provide for greater transparency as to how user fees are allocated among funding for exchange-related activities and services and adjust fees so that they are commensurate to the services provided by the FFE.

Rationale: Anthem cannot support an increase in the SBE-FP user fee in the absence of greater transparency regarding the use of the fee. While HHS indicates that the SBE-FP user fee is applied to cover the cost of using the federal platform as a portion of federal spending on federal exchange activities, the actual costs of HHS exchange activities is unknown to the public. HHS should make these costs more transparent to facilitate necessary collaboration among the federal government and other stakeholders to determine where spending is excessive and what should be done to lower system costs and thus reduce user fees. Increasing user fees can negatively impact plan affordability in the exchanges, and could dissuade issuers from offering products in SBE-FP states – hurting enrollee access and competition.

While Anthem appreciates that the FFE user fee has not increased, the continued transition of certification and compliance responsibilities to states and platform and operation activities to third-parties should allow for future reductions in the FFE user fee. HHS should work with stakeholders to isolate the cost to the government and the kinds of services that the FFE continues to provide. In addition, HHS should ensure that no user fees are diverted to non-exchange functions, and that issuers are issued refunds or credits should more funds be collected than are necessary to operate HealthCare.gov.

PREMIUM ADJUSTMENT PERCENTAGE, MOOP LIMIT, AND REQUIRED CONTRIBUTION PERCENTAGE (§156.130 and §155.605)

Issue: HHS proposes a maximum annual limitation on cost-sharing (Maximum Out-of-Pocket, or MOOP) in 2019 of $7,900 for self-only coverage and $15,800 for family coverage. As in previous years, HHS proposes to maintain the requirement of embedded self-only maximums within family coverage. This requires a plan to not require cost-sharing higher than the self-only amount for any one person in a family coverage.

Recommendation: While not addressed in the proposed NBPP, Anthem recommends that HHS add flexibility for issuers to create plans with or without embedded individual MOOPs.

Rationale: Issuers spend considerable time creating plan designs that appeal to consumers with a wide range of coverage and affordability interests. The requirement of embedded MOOPs (where cost-sharing amounts for any individual, whether enrolled in self-only or other than self-only coverage, cannot exceed the MOOP for self-only coverage) was not included nor intended to be a requirement in the ACA. In fact, this requirement was not included until the 2016 NBPP. So long as plans do not apply a MOOP that exceeds the annual limitation on cost-sharing, we believe issuers should have the option of offering plans
with both aggregate (family MOOP applies to all members) and/or embedded MOOPs. We believe that giving issuers flexibility in using both aggregate and embedded MOOPs could allow for expanded issuer innovation and lead to greater plan affordability. Removing embedded MOOPs in some plans may allow issuers to reduce premiums, and offer a greater range of coverage options that could incentivize younger and healthier consumers to enroll – helping to stabilize the individual market.

**MEANINGFUL DIFFERENCE (§156.298)**

*Issue:* HHS proposes to eliminate the meaningful difference standards for QHPs offered through an FFE or SBE-FP.

*Recommendation:* Anthem supports the removal of the meaningful difference standards.

*Rationale:* Anthem agrees with HHS that with fewer issuers participating in the exchange and fewer plan options for consumers, the meaningful difference standards are no longer necessary. We further believe that removal of these standards will afford issuers greater flexibility to develop high-quality, affordable plans that meet enrollees’ coverage needs.

**QUALITY RATING SYSTEM (§156.1120)**

*Issue:* HHS is not recommending changes to the Quality Rating System (QRS) in the proposed rule, but requests feedback on how to account for social risk factors in the QRS and on what types of social risk factors may be most appropriate to consider. HHS seeks comments on which social risk factors could be used alone or in combination, data sources from which HHS could gather information on the impact of social risk factors, and whether there are data gaps that, if filled, could allow for better or additional data to be collected.

*Recommendation:* While Anthem supports adjusting quality ratings for social risk factors, we urge HHS to work with stakeholders to ensure that these risk factors are properly accounted for in any QRS changes.

*Rationale:* Anthem agrees that it is critical for all quality rating frameworks – including the QRS – to appropriately consider the impact of enrollee social risk factors on plan quality scores. Numerous studies have documented the potential impact of social risk factors, such as income, on plan performance and quality scores. For example, beneficiaries with limited income may have difficulty securing transportation to medical appointments, which could impact both clinical outcomes and member ratings of provider and service availability. Therefore, failing to account for differences in plan enrollee populations with respect to these social risk factors could distort plan quality ratings, creating an uneven playing field among plans and ultimately reducing the meaning and relevance of these ratings as a consumer decision-making tool.
While we agree that it is critical to address the impact of social risk factors on plan quality ratings, we believe that additional work is needed in this area. As Anthem has noted with respect to the proposed addition of social risk factors in other programs such as the Medicare Advantage Star Ratings, we believe that this is a complicated issue and that more work is needed to ensure that social risk factor information can be accurately collected and applied in a consistent and fair manner. We recommend that HHS work with issuer, provider, and enrollee stakeholders to design methods for the collection and application of information social risk factors.

ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS
($158.162, §158.170, §158.221, §158.301, §158.321, §158.322, §158.330, §158.341 AND §158.350)

Reporting of Federal and State Employment Taxes in MLR ($158.162)

Issue: The MLR calculation requires federal and state taxes be excluded from premium revenue. The 2016 NBPP clarified that employment taxes should not be excluded from earned premiums. HHS is seeking comment on whether they should change their regulations to allow for the deduction of employment taxes starting with the 2017 MLR calculation and on the effect of such a change on market stability. HHS also seeks comment on whether employment tax data should be collected separately for MLR reporting purposes in order to inform a final decision on this issue.

Recommendation: Anthem supports HHS’ decision to allow federal and state employment taxes to be excluded from earned premiums beginning with the 2017 MLR reporting, and we do not believe that issuers need this data to be collected separately in the MLR report.

Rationale: The ACA clearly specifies that all federal and state taxes are to be excluded from premium in the MLR calculation. There was no rational basis set forth in the 2016 NBPP for altering the statutory requirement. The MLR provision in the ACA describes the denominator in the MLR calculation as “the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees....)” From 2011 to 2015, HHS permitted issuers to exclude all federal and state taxes from their MLR calculations, and there was no basis for deviating from the statutory language.

Reporting of Quality Improvement Activity Expenses for MLR ($§ 158.170, 158.221)

Issue: Currently, issuers are to include Quality Improvement Activity (QIA) expenses, in the numerator of the MLR calculation, but QIA expenses must be specifically accounted for. HHS noted that while most issuers generally report low QIA expenses of less than 1 percent of earned premium, accounting for these expenses generates significant administrative burden. Therefore, HHS is proposing an option for issuers to include a standard 0.8 percent QIA amount in the numerator of the MLR calculation starting with the 2017 MLR reporting year. Plans that wanted to track and report QIA expenses could still do so.
Recommendation: We support the proposal that issuers be given the option to use a standard 0.8 percent of earned premium as a proxy for QIA expenses in the MLR calculation and appreciate that issuers spending more than 0.8 percent of earned premium on QIA expenses have the option to maintain the current tracking and reporting processes. Anthem also recommends that HHS clarify that an issuer can choose the QIA expense default of 0.8 percent of earned premium for one market segment while maintaining the current tracking and reporting process for a different market segment. Anthem believes that HHS should permit issuers to include in their MLR calculations additional QIA expenses that align with the Administration’s priorities, including anti-fraud efforts and investments in the development of new payment models, as well as agent and broker commissions.

Rationale: Anthem supports HHS’ efforts to reduce administrative burden, especially when it adds little consumer value. Reduction of administrative expense and burden can help to keep premiums affordable for consumers. Anthem also urges HHS to permit issuers to include as QIA expenses health plans’ investments to improve quality and efficiency in care delivery, including fraud detection and prevention as well as expenses attributable to the development of new payment models that improve quality of care for patients. By maintaining robust fraud detection and prevention programs, health plans are helping reduce costs across the system and protecting consumers from fraud, waste, and abuse. However, the MLR regulations do not currently permit issuers to include most of their fraud prevention expenses in the MLR calculations. Permitting issuers to include a greater amount of their fraud prevention expenses in the MLR calculation aligns well with the Administration’s emphasis on program integrity in this rule.

The proposed Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (2019 Medicare Rule) just released on November 16 supports our position. In that rule, HHS proposes to allow Medicare Advantage plans to include in the numerator of their MLR calculations expenses for fraud detection, prevention, and recovery. HHS notes that it is proposing this change because limiting or excluding amounts invested in fraud reduction undermines the federal government’s efforts to combat fraud in the Medicare program, and reduces potential savings to the government, taxpayers, and beneficiaries. Similarly, disallowing issuers’ fraud prevention expenses in the commercial health insurance MLR calculation has undercut issuers’ incentives to maintain robust anti-fraud programs, and has likely increased the overall cost of health insurance. Further, if the HHS proposal in the 2019 Medicare Rule is finalized without a corresponding change in the commercial MLR rules, fraud perpetrators will likely shift their focus to the commercial health insurance market, adding to the cost of health insurance. Fraud prevention programs, which can improve health outcomes and lead to higher quality care, should be encouraged and supported in both public and private health care programs so that fraud is consistently controlled throughout the health care industry.

Moreover, plan investments in quality improvement and new care models – such as investments in patient engagement tools and partnering with providers to deliver care more effectively and efficiently – are not currently included as QIA expenses in the MLR calculation. As a result, incentives for plans to undertake
activities that reward quality and value and that improve health care outcomes are not properly reflected in their MLR calculations. In addition, agent and broker commissions are considered administrative expenses under the current MLR calculation methodology. HHS should permit issuers to either deduct agent/broker commissions from earned premium, or include them as QIA expenses. Permitting issuers to subtract commissions from the MLR calculation aligns with HHS’ goal of expanding the use of agents and brokers in the enrollment process.

State Individual Market MLR Adjustment Requests (§§ 158.301, 158.321, 158.322, 158.330, 158.341, 158.350)

Issue: The current minimum MLR for the individual market is 80 percent. Under current regulations, the Secretary may adjust the 80 percent MLR threshold in a state if the state can demonstrate that the application of the 80 percent threshold has a reasonable likelihood of destabilizing the market. HHS’ proposed change would allow the Secretary to make a state adjustment if the state can demonstrate that lowering the MLR threshold could help stabilize the individual market. HHS also proposes to streamline the process for applying for MLR threshold reductions. Specifically, HHS notes that many items required for the application to change a MLR threshold are already reported as part of other requirements or may not be necessary at the level of detail currently required (e.g., individual market enrollment and premium data). HHS will maintain the requirements to report total earned premiums, agent and broker commissions, and Risk Based Capital (RBC) for each issuer with more than 1,000 enrollees. This would be limited to issuers actively offering coverage in the individual market; however, data would be broken out by market type (grandfathered, on-exchange, off-exchange, and transitional). HHS proposes and seeks comment on changes for a state-requested MLR threshold. The change would only require that the state submit information on how the proposed changes would help stabilize the individual market, but other requirements of §158.322 would be removed, specifically requirements to provide a justification of the adjustment determination, estimate rebates, and how issuers would meet the 80 percent threshold as soon as applicable.

Recommendation: Anthem supports greater state flexibility in setting its individual market MLR rates where the state believes it would help stabilize the individual market. We believe states could effectively use this flexibility to encourage greater participation and competition in their markets. We seek clarification that the streamlined process is available only to states that are requesting a lower MLR threshold in order to stabilize their markets.

Rationale: We agree that states should be given the flexibility to lower the MLR threshold to help stabilize the individual market, and we appreciate the streamlined requirements for states choosing to lower the MLR threshold to stabilize their markets. While an 80 percent MLR threshold may be appropriate in some states, in other states having a lower MLR rate may have competitive benefits that outweigh potential costs – and we believe states are in the best position to make those trade-off assessments. We seek clarification that the streamlined process is available only to states that are requesting a lower MLR
threshold in order to stabilize their markets.

We also note that HHS did not specify a timeline or effective date for these changes. We recommend that, if the state adjustment is meant to be available for the 2019 benefit year, HHS provide notice of state adjustments for the 2019 benefit year no later than January 31, 2018. If this timeline cannot be implemented, we recommend that state adjustments should only be permitted for benefit years 2020 and later.

**MLR AND THE 2017 DELAY IN THE HEALTH INSURANCE TAX (HIT)**

*Issue:* Due to the 2017 HIT moratorium, if an issuer was in a MLR rebate position in 2017, the issuer would be required to return the portion of the premium it collected in 2017 for non-calendar year plans that is needed to pay the 2018 HIT for those plans.

*Recommendation:* Anthem recommends that HHS allow issuers to defer premium collection for non-calendar plans for 2017 MLR filings in the same manner as it did for 2013. This adjustment would be indicated in the Office of Management and Budget (OMB) MLR Instruction Manual.

*Rationale:* For the first year of the HIT, in MLR filings HHS allowed issuers to defer until 2014 the premiums collected for non-calendar plans in 2013. This was needed in order to allow issuers to align HIT fees collected in 2013 with the related 2014 premiums. Due to the 2017 HIT moratorium, issuers will be in a similar situation in 2017 and 2018. As a result, we recommend a similar treatment for the 2017 MLR filings, to address this issue, and align HIT fees with related premiums, as previously recognized, and consistent with accrual accounting principles and practices.

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Anthem appreciates this opportunity to provide feedback on this proposed rule that will help issuers operate inside and outside of exchanges. We look forward to working with HHS to uphold the objectives outlined above. Should you have any questions or wish to discuss our comments further, please contact Judi Langer at (414) 267-7467, or Judith.A.Langer@anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy