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Humana Plows Ahead Amid Speculation of Its Own Megadeals

Humana Inc. has kept a low profile over the past year after abandoning a proposed acquisition by Aetna Inc. amid antitrust concerns — up until now, that is. Humana is back in the headlines amid a March 29 *Wall Street Journal* report speculating that it is in talks with Wal-Mart Stores, Inc.

The managed Medicare specialist has outlined a steady course for investors after its mutual decision with Aetna last year not to appeal court rulings blocking the deal on antitrust grounds *(HPW 2/20/17, p. 1)*.

Meanwhile, several of Humana's insurer rivals are pursuing PBM-centered strategies. CVS Health Corp. in December agreed to acquire Aetna *(HPW 12/11/17, p. 1)*, a transaction still undergoing regulatory scrutiny. The companies in the more acrimonious managed care megadeal that failed in early 2017 — Anthem Inc.'s $54 billion effort to acquire Cigna Corp. — also have moved on. Anthem plans to introduce its own PBM IngenioRx in 2020 in partnership with CVS *(HPW 10/23/17, p. 1)*, and, most recently, Cigna unveiled a deal to grab the last remaining pure-play PBM, Express Scripts Holding Co., for $67 billion *(HPW 3/12/18, p. 1)*.

As for Humana, the company said in December it agreed to pay about $800 million under a joint venture to acquire a 40% minority interest in Kindred Healthcare, Inc.'s home care division *(HPW 12/25/17, p. 1)*. Since then, the Louisville, Ky.-based insurer's announcements have focused on such matters as addressing social determinants of health and improving patient engagement for Medicare beneficiaries. On March 27 Humana declared a quarterly dividend of 50 cents per share, up from its prior dividend of 40 cents per share.

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Insurers, Experts See Stabilizing ACA Individual Marketplaces

Congress' latest failure to pass an Affordable Care Act (ACA) stabilization package, taken together with policy changes that have chipped away at the law, have renewed concerns about spiking premiums and insurer exits in the marketplaces next year.

However, some insurers have already publicly stated their commitment to the individual exchanges, and experts say they think carriers are mostly in a good position to weather the challenges they face — though perhaps with a little help from state regulators.

Premera Blue Cross, for instance, is working with Washington state's insurance department to explore how to secure funding for a high-risk pool, Jim Havens, senior vice president of individual and senior markets, tells AIS Health.

"There seems to be a lot of interest in that, in moving that forward. It's complicated and it's challenging, but we're very encouraged," Havens says, adding that it would help bring down premiums for the unsubsidized population — though not

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likely until 2020. He declines to disclose specific premium projections.

Still, the insurer said March 12 that in part due to the benefits it will receive from tax reform, it told Washington and Alaska regulators that it "remains committed" to serving customers in the individual market in 2019 *(HPW 3/19/18, p. 8)*.

In 2019, Premera says it will continue covering the three rating areas it currently covers in Alaska, while it will increase the number of rating areas it covers in Washington from five to nine. The insurer currently has 18,400 effectuated ACA exchange enrollees in Alaska and 49,000 in Washington.

"Our commitment all along has been to the exchange and to the broadest population possible," Havens adds.

Another insurer that refuses to back away from the exchanges is Medicaid managed care powerhouse Centene Corp.

The company expanded exchange offerings into three new states in 2018 and now has 1.6 million effectuated marketplace enrollees out of 12.2 million total medical members, Senior Vice President of Products Kevin Counihan said March 10 at America's Health Insurance Plans' National Conference on the Individual and Small-Group Markets.

"I think when you look at the financial performance of issuers … over the past year, the news is very favorable. So we're very aggressive about our role in the exchanges [and] think that the market is stabilizing in a good way, recognizing that this is a highly dynamic business which is going to continue to evolve," said Counihan, who previously served as the CEO of HealthCare.gov.

"But we think that the marketplace is here to stay."

Premiums Are Likely to Rise

Though insurers like Premera and Centene are committed to sticking it out on the ACA exchanges, the marketplaces are still facing challenges.

One of them is the repeal of the tax penalty associated with the individual mandate, which goes into effect in 2019 and is likely to drive premiums higher, according to a recent analysis from the left-leaning Urban Institute.

The analysis, which summarizes the findings from interviews with 10 insurance companies, said some insurers were worried the repeal would lead to a collapse of the market, while others were confident there would continue to be a robust market for highly subsidized customers.

To S&P analyst Deep Banerjee, the "big thing about 2019" will be the repeal of the individual mandate. While he says he doesn't think that the disappearance of the individual mandate will cause a meaningful decline in ACA exchange enrollment, he does predict insurers are likely to respond by raising their rates.

Factoring in a combination of how insurers respond to the mandate repeal — which Banerjee cautions will vary considerably — plus the typical medical cost trend increase, it's "quite possible" that rate hikes for the second-lowest cost silver plan, also called the benchmark plan, could average in the low teens in 2019, he says.

The average monthly premium for a benchmark ACA exchange plan for a 27-year-old increased by 37% from plan year 2017 to 2018, according to HHS.

> **"We're very aggressive about our role in the exchanges [and] think that the market is stabilizing in a good way, recognizing that this is a highly dynamic business which is going to continue to evolve.**

Another issue that insurers said could raise premiums, per the Urban Institute report, is the expansion of short-term and association health plans, as directed by President Trump's executive order *(HPW 2/26/18, p. 1)*. That's because expanding such plans could siphon healthy people away from the ACA exchanges, the report said.

In Banerjee's view, those policy changes likely won't meaningfully alter the risk profile of the ACA marketplac-

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es, since many exchange enrollees likely need the more comprehensive coverage afforded by ACA-compliant plans.

"But it's important to note — it doesn't improve the market," he adds.

Banerjee is less concerned, though, about the impact of the lack of funding for cost-sharing reduction (CSR) payments.

"I hate to call it this, but going forward, the lack of CSRs is almost a non-event, because insurers have adjusted to the fact that actual CSR payments won't happen in the future," he says.

Chiquita Brooks-LaSure, a managing director at Manatt Health who helped implement the ACA as part of the Obama administration, had a similar take.

CSRs Are Not 'Going to Really Be a Factor'

"I think that the CSR issue started out as a very difficult one for plans and for states because it happened so abruptly," she says, referring to when the Trump administration decided to halt the payments in October. But because state regulators stepped up to help insurers account for the lack of funding, "I don't think that the CSR issue is going to really be a factor" in whether some insurers decide to exit the exchanges, she adds.

The ACA stabilization package that some lawmakers hoped to include in Congress' most recent budget bill would have funded CSRs for three years, but support for it foundered in part due to partisan disputes over language to prevent federal funding from covering abortions *(HPW 3/26/18, p. 8)*.

Yet a March 20 report from the Center for Budget and Policy Priorities raised questions about whether funding CSRs would do more harm than good since it would actually reduce subsidies for many moderate-income individuals.

Some insurers had the same view, noting that "proposed legislation to restore cost-sharing reduction funding could result in significant disruption and sticker shock for consumers receiving premium tax credits," the Urban Institute analysis said.

Unsubsidized Enrollees Raise Concerns

For Premera, the CSR funding issue is an "interesting one," Havens says, because it's not a major problem in Alaska, where 93% of the individual market population is subsidized and thus largely shielded from premium increases.

But it's more problematic in Washington, where only 60% are subsidy-eligible, leaving the remaining 40% to bear the full brunt of premium hikes. The lack of CSR funding "hurts that population disproportionately," Havens says, which is why Premera is working with state regulators to find a solution like setting up a high-risk pool.

> **"I think the ability to educate, which sounds so simple and so basic, but remains an ongoing challenge for our industry, [is important].**

He's also hopeful that discussion will continue at the federal level on reinsurance, even though the ACA stabilization measure was tabled.

"I think we were a little disappointed that the market stabilization effort that was going on in this last session didn't go through, but we're going to continue to watch that closely and see if there aren't things from a bipartisan perspective that can get done to help stabilize the market and reduce premiums for everybody and addresses the cost of care," Havens says.

Brooks-LaSure echoed Havens' sentiment, saying moves like the individual mandate repeal, the end of CSR funding and the lack of movement on reinsurance funding at the federal level "really puts into question what's happening to the unsubsidized market, the people who are paying out of pocket, and that's definitely a big concern for the marketplaces."

On the other hand, "I think what we're going to see is the subsidized market — people who are getting tax credits — are largely doing OK and are likely to continue to get coverage, and so from that perspective, insurers do have a critical market in most states where they know that those people will probably want coverage," she says.

Experts Emphasize Outreach

To ensure that the ACA exchanges continue to be viable markets for both insurers and consumers, allocating funding for reinsurance is "one of the key things that Congress could do," Brooks-LaSure says.

She says it will also be critical for the administration to ensure that HealthCare.gov continues to run smoothly and that outreach to consumers remains robust.

"I think that's a critical piece of making sure that the marketplaces are working, by making sure people are aware of coverage being out there and also making it easy for people who are interested to enroll," she says.

Insurers have a part to play in making the exchanges work for customers as well, according to Counihan. He pointed out that when he was at CMS, he found enrollees' health literacy "grew every year."

"I think the ability to educate, which sounds so simple and so basic, but remains an ongoing challenge for our industry [is important]," he said. "And to do it in a way that's very tangible to these individuals."

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For more information, read the Urban Institute report at https://rwjf.ws/2GH6HEN and the Center for Budget and Policy Priorities report at https://bit.ly/2GgUqXW. ✧

by Leslie Small

Medicaid Plans Brace for More Policy, Regulatory Changes

The Medicaid landscape is undergoing rapid transformation as the Trump administration loosens some benefit and policy limitations and states tackle prescription drug costs with new approaches, according to analysts from health care consulting firm Avalere Health.

In a recent webinar hosted by Avalere, titled "Medicaid: Adapt to the Changes," Megan Olsen, a manager at Avalere, flagged two catalysts that may drive Medicaid policy changes in the near term: continued activity on 1115 waivers and a Medicaid managed care regulation, expected out in late summer or early fall, that may provide additional flexibility for plans.

Longer term, the 2018 mid-term elections could change the political balance in Congress and in 36 states holding gubernatorial elections.

Those races will help shape policy decisions around Medicaid expansion, opportunities to control drug spending, Medicaid managed care and more, Olsen said.

Among the state Medicaid policy efforts Avalere says states are currently focusing on:

✦ ***Creating benefit time limits and lock-out periods,***

✦ ***Requiring work and community engagement activities,***

✦ ***Adding wellness programs, increasing premiums and cost sharing,***

✦ ***Reducing expansion eligibility levels, and***

✦ ***Limiting drug coverage, network size and other benefit design components.***

Tiernan Meyer, a senior manager of policy at Avalere, said that CMS's recent guidance easing Affordable Care Act (ACA) restrictions has allowed states "some additional wiggle room" to change Medicaid policies through 1115 waivers, particularly to add work requirements *(HPW 1/29/18, p. 1)*. "We've been seeing a lot of discussion between states and federal regulators on a different approach to Medicaid benefits and eligibility, and especially a focus on waivers," she said.

Some states are exempting certain diseases from work requirements, such as cancer or tuberculosis, or have specified certain age groups that are exempt from work requirements, Meyer said. Proposed requirements include work, school, job training or health education activities for 8 to 20 hours per week. Some states also are evaluating redetermination requirements.

As of March 5, Avalere has tracked five states with proposed and/or approved work requirements that could lower Medicaid enrollment:

✦ ***Kentucky's*** enrollment could drop by 95,000 by 2022.

✦ ***Indiana*** could have 31,000 fewer recipients by 2020.

✦ ***Maine*** could lose 5,000 members by 2022.

✦ ***Wisconsin's*** enrollment could drop by 5,000 by 2023.

✦ ***Mississippi*** could lose 3,000 recipients by 2022.

In addition, according to Avalere, seven states are planning to propose work requirements, but do not yet have estimates on the number of enrollees that will fall off the program due to work requirements.

Funding Change Is Still in Play

Olsen noted the ongoing Republican effort to move Medicaid from an open-ended funding structure to a more fixed financing structure. "There are two flavors of this," she said: a per capita cap, with a fixed amount per beneficiary, or a block grant to manage a state's whole Medicaid population.

A fixed financing methodology would help establish a baseline for Medicaid spending and likely would tie it to a lower growth rate than what is currently expected.

Avalere's analysis found both of these proposals would result in significant decreases in Medicaid funding, with a lot of variability by states. The decreases in federal funding would range from -6% to -26%. States that expanded Medicaid would experience the biggest decreases, she said.

This raises a whole host of considerations for states, Olsen said. They have several options; they might seek to tighten eligibility criteria or reduce the income threshold. They may implement work requirements, seek to re-

duce coverage benefits or set a limit on certain benefits. New sources of funding could include new taxes or spending less on other parts of state budgets. It's likely that states will pursue a variety of these strategies, she said.

As for drug benefits, states are moving beyond traditional cost management tools such as formulary lists and supplemental rebates to test drug spending caps, closed formularies, mandatory supplemental rebates and outcomes-based contracts, Avalere said.

States Retain Control of Drug Benefits

Even as more states have deployed managed care plans to help manage costs, they have retained control of formularies. Avalere estimated that by 2021, just 21% of Medicaid recipients would be in a state-run fee-for-service Medicaid program, down from 41% in 2012. But by 2021, 27% would have managed Medicaid benefits with state-controlled drug coverage, up from 12% in 2012, while 52% would have a managed care formulary, up from 47% in 2012.

Among states testing new drug strategies, Massachusetts and Arizona have proposed adoption of a closed formulary with a minimum number of drugs per therapeutic class. They would exclude drugs that have "limited or inadequate clinical efficacy evidence," Avalere said. Meanwhile, New York enacted a law establishing a Medicaid drug spending cap. If drug costs exceed that cap, Avalere said, the state can require supplemental rebates from manufacturers or apply stricter access standards.

See the Avalere slide deck from the webinar at http://bit.ly/2tDTPts. Contact Meyer at tmeyer@avalere.com and Olsen at molsen@avalere.com. ✧

by Diana Manos

Jump in Urgent Care Claims Indicates 'Paradigm Shift'

As the health insurance industry continues to focus on site-of-care management, new data indicate those efforts may be influencing consumer behavior.

From 2007 to 2016, private insurance claims for urgent care services increased by 1,725%, according to a new white paper from FAIR Health. The growth in urgent care claims was more than seven times that of emergency room claims, which grew 229% in the same period.

Retail clinic claims, meanwhile, rose 847% between 2011 and 2016, the study showed.

To FAIR Health President Robin Gelburd, the data make it clear that alternative care venues are gaining ground.

"We're kind of experiencing, really, some paradigm shifts in the way in which health care is getting delivered and the kind of appetite consumers have for different venues of care," she tells AIS Health.

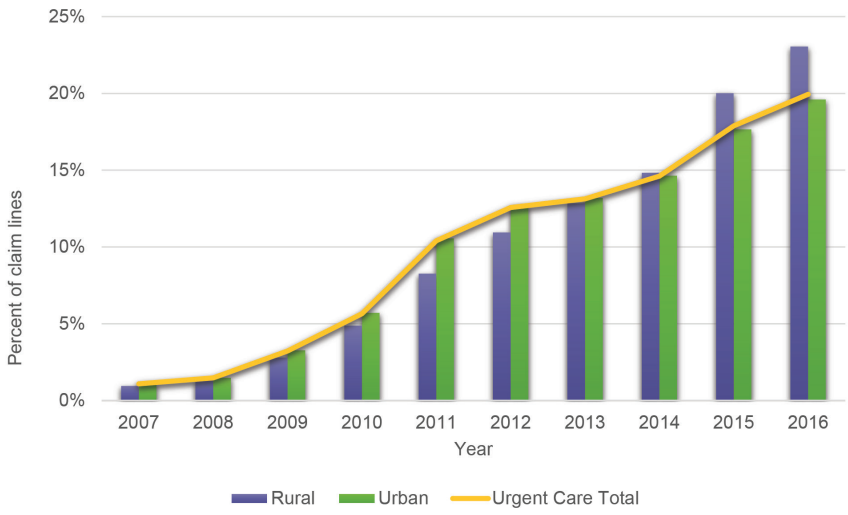
Gelburd says one factor that may be fueling the trend is increased consumer education about appropriate ER use.

Insurers have been driving that point home for some time, arguing that going to the ER for non-emergencies both wastes consumers' time and drives up health care costs. Anthem even denies coverage of ER care for certain conditions that would be better treated elsewhere — though that policy has also drawn considerable criticism *(HPW 1/29/18, p. 2)*.

"So as that type of information gets disseminated to consumers about when you may want to choose a different venue other than emergency department — because that can be quite expensive and take you down a path that may not be necessary — urgent care centers are filling that need," Gelburd says.

Another reason for the increased use of alternative care venues may be

Urgent Care Claims Rise Sharply



SOURCE: FH Healthcare Indicators and FH Medical Price Index, FAIR Health. Visit https://www.fairhealth.org.

the gains in insurance coverage brought about by the Affordable Care Act, according to Gelburd, who adds that the urgent center proliferation may be reflecting some primary care access issues.

The study didn't measure, though, whether the increase in urgent care claims was primarily redirected volume from the ER or physician offices or new volume from people who otherwise wouldn't have sought care.

One surprising finding that FAIR Health uncovered, according to Gelburd, had to do with the growth of telehealth claim lines. Although rural growth outpaced urban growth from 2014 to 2015, urban usage not only caught up with, but surpassed, rural growth between 2015 and 2016.

Often people think of telehealth mainly as a vehicle for people in rural areas to access certain types of specialty care outside the bounds of where they live, she says, whereas urban residents wouldn't be as likely to have that problem. But while that is true, the new data indicate to Gelburd that there's "an appetite for telehealth also for convenience purposes."

Retail clinics saw a similar rural-urban reversal, the report said, with rural growth stronger between 2011 and 2016 "likely because of a greater need in rural areas for easily accessible primary care and diagnostic care."

In addition, urban retail clinic growth outpaced that of rural growth starting in 2016, which might be because of "less restrictive regulations and/or limited access in more traditional primary care settings," the report added.

Contact Gelburd via Dean Sicoli at dsicoli@fairhealth.org. View the FAIR Health report at https://bit.ly/2GiGbC7. ✧

by Leslie Small

Humana Stays the Course, for Now

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The bottom line? Humana's conservative, steady course may present opportunities as well as challenges, two longtime managed care industry consultants tell AIS Health.

"As a business model, Humana is going to plug right along, is going to do fine, is going to produce reasonable returns…but it isn't going to turn into a mega-company," says Stephen Wood, co-owner and partner of Clear View Solutions, LLC, a Chicago-based management consultancy focusing on government-sponsored health insurance programs.

"Everybody seems to want to imitate UnitedHealthcare with vertical integration," Wood says. "United's been at it 20 to 25 years, but [now] with health plans buying PBMs and PBMs buying health plans, and you slam together companies — it almost makes Humana a safer bet."

In general, health plans "have been increasingly focusing on becoming 'healthcare companies' rather than just one thing or another," says Chris Sloan, a director at Avalere Health. "We've seen multiple plans acquire provider groups, as well as PBMs, to vertically integrate the entire healthcare delivery system. With the increased focus on payment for value and quality, being able to achieve savings throughout the entire healthcare system (providers, plans, PBMs) is an attractive proposition for these entities."

Humana Is a 'Respected Competitor'

Against this backdrop, Humana offers good products, a solid footprint in discrete markets, loyal customers and a keen knowledge — beyond most of its peers — of retail sales and direct-to-consumer marketing skills, Wood says. He describes Humana as "a respected competitor to our clients. They run a pretty tight ship."

But Wood asserts there could be limitations on how Humana strengthens its footprint in the marketplace. "As a company, Humana is very well respected in the Medicare Advantage space, but it doesn't really have knock-me-over growth and integration…and there aren't a lot of new markets" for expansion, he says. He further notes that the insurer, with its national brand presence, "needs

to generate a big presence when they enter a market."

Humana is "still a prime acquisition target," Wood says. He predicts that "something will happen to Humana reasonably soon" — in terms of its being acquired or making an acquisition — but he notes the insurer's dominance in south Florida's marketplace eliminates some potential partners.

Wood describes mixed feelings about Humana's Kindred deal. He says it "could push Humana in an interesting and new direction, but CareCentrix [a company using technology and analytics to address post-acute care needs and help patients recover at home] has been at it for quite a while," he says. "I don't think the home health business is going to advance its [i.e., Humana's] interests and won't add to earnings."

Is Insurer's Path 'in Charge of Others'?

Moreover, Wood asserts that Humana is facing outside forces as it navigates its course. "I'm not sure [Humana]'s in charge of charting its path," he says. "I think its path is in charge of others," he says. "The Humana/Aetna deal —everybody thought it would go through and it was going to be great; and when that didn't happen, I think it took the wind out of their sails."

Wood says it makes sense that PBMs haven't put together deals with the insurer. "Look at what Humana is and what it's not," he says. "From my perspective, as a Medicare guy, they're the bomb — but their commercial side of the business is really weak and they don't have the footprint [of other major carriers]. And if you're a PBM, you're looking at volume of tens of millions of lives that need to feed the beast. So, I think it was more about the commercial side, not Medicare, that drove the PBM focus" in recent megadeals.

"But, at the end of the day, Humana may not be in a bad place" if the company stays the course, Wood says. "They're making money *(HPW 2/12/18, p. 1)*, plugging along…. They're a well run, well respected, conservatively growing company."

Is Humana's Medicare Focus Enough?

Ashraf Shehata, a principal in KPMG's health care life sciences advisory practice and in its Global Healthcare Center of Excellence, notes that Humana has targeted the Medicare space for a long time, and was one of the first managed care companies to do so. Humana's focus on the Medicare market is "very positive," he says. "But, can you sustain yourself with Medicare products? Or, in an age of megadeals [and vertical and horizontal] mergers, do you need more than that?...I feel that's a reasonable question."

Shehata points out that Medicare Advantage has many other players, including newcomers, "going into the hotly contested space," especially at the local and regional levels. "We have to believe Humana is looking at all options to create better integration — so, is it enough? Right now everybody seems to be asking that question and coming up with all sorts of alternatives to expand their target scope," he says.

As for last year's failed merger between Humana and Aetna, Shehata sees a lingering effect. "Humana had good intentions," he says. "Even though Aetna and Humana didn't work out, they hoped for scale for better positioning [in the marketplace], and the desire is still there."

What of PBM alignment? Shehata describes Centene Corp.'s recent announcement of its initial investment in RxAdvance, a tech-savvy PBM, as notable because it is an example of a good strategic fit between a managed care organization and a PBM — and because it seems geared toward the Medicaid managed care population.

"If you believe there's a PBM model designed for Medicaid plans, maybe there's a model for Medicare plans," Shehata says, "so there could be an opportunity for further integration" by Humana, he says. "Some people would say most PBMs are designed for seniors anyway," because of typically heavier prescription drug use by seniors, he adds.

> **"We have to believe Humana is looking at all options to create better integration — so, is it enough?**

Wood says he wouldn't disagree with Shehata's premise. "But all large PBMs are quite familiar with Medicare [and already] involved with PDPs [i.e., Medicare Prescription Drug Plans]," he says. "It seems to me the logical marriage would be [Rite Aid Corp.'s] Envision[Rx] and Humana….Envision was also left at the altar — it was going to be a part of Walgreens — and they're very responsive to senior markets and Medicare. But [such a deal] is second tier. But maybe Humana is now second tier."

In any event, Shehata sees opportunities for Humana and perhaps other health insurers extending into other areas.

"What about retail [and putting the company's capabilities around direct-to-consumer efforts]? That's a reasonable question," he says. "So, all the options, I think, are on the table — for Humana, the Blues and others."

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by Judy Packer-Tursman

News Briefs

✦ ***The Washington state Office of the Insurance Commissioner imposed a $100,000 fine on Coordinated Care Corp. for failing to take adequate steps to fix problems with its provider networks that in December led the state to briefly ban the Centene subsidiary from selling individual plans.*** The state lifted that cease-and-desist order after Coordinated Care agreed to a compliance plan and a $1.5 million fine — $1 million of which was suspended pending no further violations over the next two years. If the company continues to violate the compliance plan, the state says it may impose some or all of the remaining $900,000 fine. Read the commissioner's statement at https://bit.ly/2G96fzF.

✦ ***Between the second and third quarter of last year, the number of opioid tablets dispensed to Capital BlueCross members dropped by 42% and the number of members using opioids dropped by 12%, according to the Harrisburg, Pa.-based insurer.*** Separately, Cigna Corp. said it achieved a 25% reduction in opioid use among its customers, reaching that milestone a year ahead of when it originally projected. View the Capital Blue Cross press release at https://prn.to/2I8eQPB and the Cigna release at https://bit.ly/2uwGnYN.

✦ ***Blue Cross Blue Shield of Michigan teamed up with 64 surgeons across seven Michigan health systems to launch a bundled payment pilot program for hip and knee replacement procedures.*** The pilot program, which will be available to fully insured employers with the Blue Cross PPO and Blue Care Network HMO products, aims to save 10% off the average cost of non-complicated knee or joint replacements. Read the press release at https://bit.ly/2Ge7Joe.

✦ ***Both Maryland's Senate and House of Delegates passed a bill aimed at bolstering the state's Affordable Care Act marketplace, the Baltimore Business Journal reported.*** The measure, which Gov. Larry Hogan (R) has promised to sign, would allow the Maryland Health Benefit Exchange to apply for a Section 1332 waiver to set up a reinsurance program that would help support the two carriers operating on the state's exchange: CareFirst BlueCross BlueShield and Kaiser Permanente. Read the article at https://bit.ly/2I9Jjwu.

✦ ***Oscar Health said it closed a $165 million funding round, which the startup insurer said will be used to fuel its next phase of growth after generating an underwriting profit in 2017 and enrolling nearly 250,000 members this year.*** Brian Singerman and Founders Fund led the funding round, with participation from Verily Life Sciences, Fidelity, General Catalyst, Capital G, Khosla Ventures and Thrive Capital, among others. The insurer is now valued at $3.2 billion, sources told CNBC. Read the CNBC article at https://cnb.cx/2J4jhMz and the Oscar blog post at http://on.hioscar.com/2GkxD9y.

✦ ***The American Antitrust Institute sent a letter to the U.S. Department of Justice urging it to block CVS Health Corp.'s pending acquisition of Aetna Inc.*** Together with Cigna Corp.'s proposed purchase of Express Scripts Holding Co., the CVS-Aetna deal "would trigger a fundamental restructuring of the U.S. healthcare system," the organization wrote, adding that "stronger incentives to exclude rival PBMs and health insurers and to engage in anticompetitive coordination would harm competition and consumers at all levels." Read the letter at https://bit.ly/2unWyYz

✦ ***Aetna said that starting in 2019, it will automatically apply pharmacy rebates at the point of sale for its commercial, fully insured members, following a similar move made by UnitedHealth Group recently.*** Aetna estimated that 3 million of its members could potentially benefit from these rebates when filling prescriptions, though it also said that the majority of rebates "have always been passed on to plan sponsors and their employees through lower premiums." Read the press release at https://aet.na/2GgRFG1.

✦ ***The HHS Office of Inspector General estimated that California made Medicaid payments totaling $738.2 million on behalf of 366,078 ineligible beneficiaries from October 2014 to March 2015.*** The watchdog agency also projected that California made $416.5 million in payments on behalf of 79,500 "potentially ineligible" beneficiaries, and said it identified a weakness in the state's eligibility procedures. Read the report at https://bit.ly/2GmEq2S.

A Monthly Update for *Health Plan Weekly* Subscribers

The AIS Report on Blue Cross and Blue Shield Plans

Blues Plans' Tax Windfall Will Fund Community, Value-Based Programs

Not-for-profit Blue Cross and Blue Shield companies, many of which are reporting positive financial results for 2017, say they expect to invest funds gained from the Tax Cuts and Jobs Act of 2017 in community-based initiatives such as those designed to combat opioid addiction, as well as in lowering premium rates and modernizing their own systems.

As the plans see stronger financial results, including in the individual market where many have struggled in recent years, they're also reporting plans to spend tens of millions of dollars on initiatives that ultimately could make their rates more competitive and bolster their bottom lines in the future, along with improving community health.

Ashraf Shehata, principal and healthcare leader at KPMG LLP in Cincinnati, says he expects insurers — including Blues plans — to use the money to purchase strategic assets that can improve their care management and agent-broker capabilities.

Other possibilities for the funds could include investments in Medicare Advantage and possibly provider acquisitions, which Blues plans had largely abandoned once the Affordable Care Act was in place, Shehata tells AIS Health.

Among publicly traded for-profit health insurers, analysts expect only a small fraction of the tax windfall to benefit members, according to an analysis by news site Axios. Most of the money will go to fund share buybacks, dividends, acquisitions and paying down debt.

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Blues Plans Face Stiff Competition in 2019 Large Group Sales Season

Blue Cross and Blue Shield plans are seeing some headwinds in a large group selling season marked by increased employer interest in high-performing narrower provider panels, improved data systems and carve-ins for specialty pharmacy, consultants say.

While the Blues brand makes those insurers relatively strong in their local markets, they're facing some struggles in competing with national insurers like UnitedHealth Group that have invested more consistently in advanced data analytics that allow them to cherry-pick providers for their narrower networks, the consultants tell AIS Health.

"The Blues have been taking some big hits, more in [politically] blue states than in red states," says Randy Vogenberg, Ph.D., a partner in Access Market Intelligence in Greenville, S.C. "Everyone is beginning to question, 'Am I getting a good deal?' Employers aren't happy, and that hurts the Blues," he tells AIS Health.

In larger cities, secondary major city markets and other high-cost areas, "the Blues haven't been performing," and their percentage of the large employer market, while still significant, isn't as dominant, Vogenberg says. "The Blues are not very flexible — it's a fundamental issue."

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William DeMarco, founder and president of Pendulum HealthCare Development Corp. in Rockford, Ill., notes that Blues plans traditionally have held a competitive advantage with large, multi-state employers who were attracted by the ability to contract with just one Blues plan while providing coverage for workers in other states via the BlueCard program. But more employers are demanding tighter, high-performing networks — which some Blues don't have. "A lot of Blue Cross organizations still aren't sure which are the best physicians."

Large employers are seeing UnitedHealth come back with competitive quotes that are addressing these questions on provider networks, DeMarco says, adding, "United probably has some of the best-performing products."

Larger Blues Quote Lower Rates

All Blues plans are not in the same boat, says Ashraf Shehata, principal and health care leader at KPMG LLP in Cincinnati. Larger Blues have worked hard to improve their administrative cost basis, and that's "starting to pay off," as improved care management and medical loss ratio starts to show up in the medical trend, making products more attractive to employer groups, Shehata tells AIS Health.

"The Blues are very successful in local markets and have very good relationships with state governments," says Shehata. "They continue to deliver products and services with a higher unit cost, but it is a brand people love." And BlueCard gives the plans a national platform they can use to sell the value of their robust provider network to multi-state employers, he says.

Along with for-profit national insurers like UnitedHealth Group, Blues also face competition from provider-owned health plans and employer coalitions that may rent a Blues network or buy claims processing from a Blues plan.

Employers Look to Value Solutions

"This could be the year large employers could become a little more vocal in revising overall plan designs," Shehata says, especially as employers search for options other than higher employee out-of-pocket contributions to offset rising premiums.

"We've heard a lot of promise for ACOs [accountable care organizations], but it still has yet to be proven out on a consistent basis," Shehata says. "For large employers, they're not seeing savings yet to the bottom line."

These plan sponsors also are focused on rising pharmacy costs, looking for more holistic benefit designs that carve in specialty drugs so that they can be effectively managed on the medical side, Vogenberg says. However, "Blues have always carved this out," and this may be costing them business, he says.

Another factor are changes to Affordable Care Act regulations under the Trump administration, Vogenberg says. "The fact that the Obamacare rules are being rolled back by Trump allows employers to have more flexibility in what they're looking at. At the smaller end of the marketplace, where the Blues dominated, fully-funded employers are now choosing to go in a self-funded direction." The Blues then "tend to lose the [self-funded] side of it in addition to losing a fully funded client," he says. "It's more cost-effective to do a self-funded initiative in the current marketplace."

Hospitals — usually one of the biggest employers in any market in the country — increasingly are moving to self-funded plans, Vogenberg adds, including in cases where the Blues plan has clashed with the hospital over reimbursement rates.

Blues Succeed in Southern States

Blues plans in the southern part of the U.S. still insure a high percentage of the population, Vogenberg says, but they aren't doing much to differentiate themselves, and "are seeing the same effects that are hitting those [Blues plans] in the northern states," he says. "'Bigger is not better' is what employers are saying….Bigger has become a problem right now, and that's where the Blues find themselves," Vogenberg adds. "The energy in finding alternatives is very high right now." And that trend should accelerate in 2019, as contracts that are longer than one year expire, he says.

To compete more effectively for large employer business, Blues need to address their "antiquated" information technology systems, which hold them back from effective data analysis, Vogenberg says.

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by Jane Anderson

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Blues Reap Tax Windfall

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For example, Anthem, Inc. posted a $1.1 billion one-time non-cash deferred tax benefit for the fourth quarter from federal corporate tax reform *(HPW 2/5/18, p. 4)*. Of that, 25% is going back to customers directly, another 25% will flow into investments, and the remaining 50% will be returned to shareholders. Anthem also will contribute to the 401(k) accounts of more than 58,000 employees and recent retirees *(HPW 2/12/18, p. 8)*.

Some not-for-profit Blues plans say they will fund initiatives in areas ranging from value-based care to early childhood care and domestic violence prevention. Among them:

✦ ***Horizon Blue Cross Blue Shield of New Jersey*** said it would invest $125 million of its tax benefit over the next five years in "significant initiatives that will drive improvements in health care for Horizon BCBSNJ members in the areas of behavioral health, access to care, and addiction." The insurer expects to gain $550 million over five years from the tax law due to changes in the alternative minimum tax (AMT).

Horizon also plans to expand programs and platforms that connect members with behavioral and mental health services; accelerate initiatives that fully integrate medical and behavioral services; invest in substance abuse initiatives; and expand access to primary care.

In addition, Horizon intends to "provide $150 million to benefit its customers," and is working with the New Jersey Department of Banking and Insurance to determine the best mechanism to accomplish this in 2018, the insurer says.

✦ ***Health Care Service Corp. (HCSC)*** says its operating income for 2017 "has returned to levels required to sustain operations while enabling the company to invest in the future." For 2017, HCSC earned $1.3 billion and grew its membership by 315,000 members, and the insurer netted another 500,000 members in January.

HCSC says the tax cuts "bolstered" its new $1.5 billion, three-year Affordability Cures program, which is aimed at cutting costs by emphasizing value-based provider arrangements, reducing variations in care and investing in technology. But "tax events don't drive our long-term business strategy," says HCSC spokesperson Jori Fine.

✦ ***Blue Cross Blue Shield of Massachusetts***, which said it lost $6.9 million after taxes in 2017, will use any benefits from the new tax law to fund "initiatives that benefit our employer customers and members, our associates/employees, and the broader community," says spokesperson Amy McHugh.

For example, McHugh tells AIS Health that the Blues plan would consider "investing in community initiatives that promote healthy living and in programs/organizations that are focused on important health care/public policy issues from serious illness/end-of-life to the opioid epidemic."

The 2017 results reflect an operating loss of $89 million and investment income of $82.2 million, the Massachusetts Blues plan says. A one-time charge related to the insurer's dental business prevented the plan from showing a modest income for 2017.

✦ ***Blue Cross Blue Shield of North Carolina*** said it earned pre-tax profits of $734 million on total revenue of $9.4 billion in 2017 and posted first-time profits on Affordable Care Act individual market plans.

The insurer says it used $40 million in tax savings to fund community health initiatives, including $10 million on several opioid initiatives, $10 million for early childhood development, $15 million on initiatives that impact the social determinants of health and $15 million to improve primary care.

In addition, the North Carolina Blues says it will use future tax law savings to lower premium increases.

✦ ***Blue Cross Blue Shield of Michigan*** said it will post a positive operating margin of $385 million on revenue of $26.9 billion for 2017, and that it added 54,862 new members for the year. It also reported a 1.4% operating margin, the first positive margin in three years.

Gains largely were driven by improved pricing in the company's Medicare supplemental business, the company said. Another key factor was strong profitability from subsidiary companies within the plan's Emerging Markets division.

Contact Shehata via KPMG spokesperson William Borden at wborden@kpmg.com, McHugh at Amy.McHugh@bcbsma.com, Horizon spokesperson Thomas Vincz at Thomas_Vincz@horizonblue.com, and Fine at Jori_B_Fine@bcbsil.com. ✧

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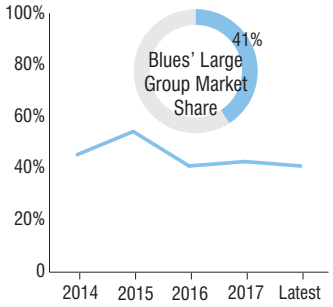
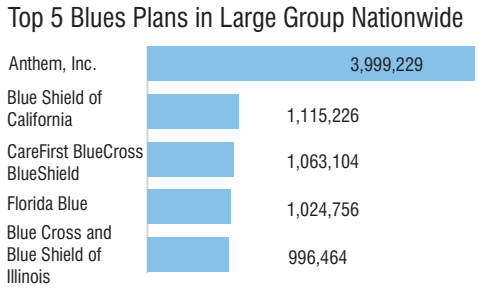
Market Overview of Blues Plans in Large Group Plans

by Jinghong Chen

Below is a snapshot of Blue Cross Blue Shield plans' share in the large group market and details on top five Blues plans in terms of large group enrollment, based on the latest data in AIS's Directory of Health Plans. About 41% of large group enrollees chose a Blues plan nationwide, down from 54.3% in 2015.

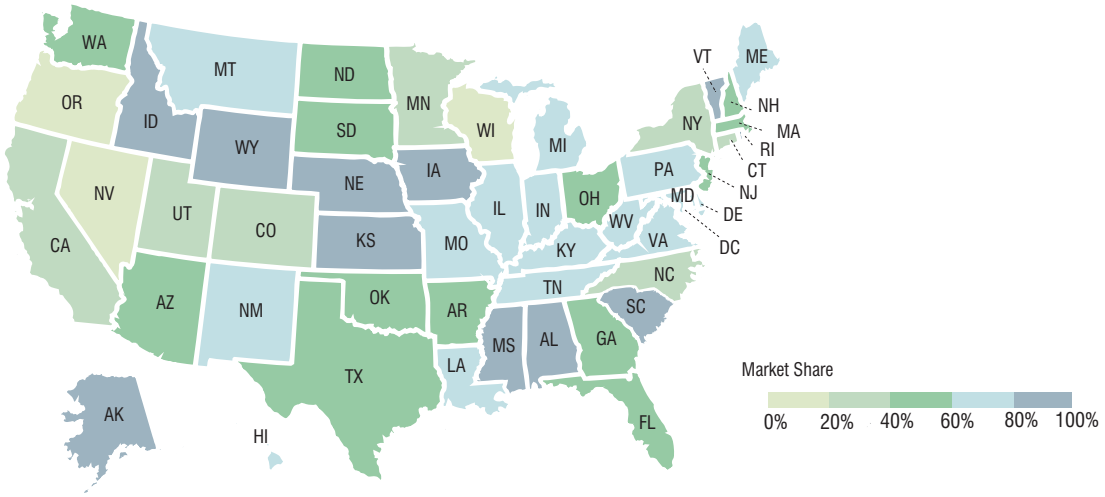




NOTE: Figures show the numbers of large group members.

Blues Plans Market Share by State

Approximately 37 million people are covered under a large group plan nationwide, and 41% of them are using Blues plans. The Blues brand dominates the large employer market in Vermont, Mississippi, Alabama, South Carolina, Nebraska and Wyoming, holding over 90% market share. Yet in Nevada, Wisconsin and Oregon, Blues plans' market shares are under 20%.



Vermont

95.4% of large group enrollees chose a Blues plan

4 insurers offer large group plans in the state

26,967 people enrolled in Blue Cross and Blue Shield of Vermont

Mississippi

94.5% of large group enrollees chose a Blues plan

6 insurers offer large group plans in the state

126,916 people enrolled in Blue Cross & Blue Shield of Mississippi

Wisconsin

16.6% of large group enrollees chose a Blues plan

21 insurers offer large group plans in the state

131,319 people enrolled in Anthem Blue Cross Blue Shield Wisconsin

Nevada

11.8% of large group enrollees chose a Blues plan

9 insurers offer large group plans in the state

43,659 people enrolled in Anthem Blue Cross Blue Shield Nevada

SOURCE: AIS's Directory of Health Plans, https://aishealthdata.com/dhp

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