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Managing Editor
Leslie Small
lsmall@aishealth.com

Executive Editor
Jill Brown Kettler

2020 Outlook

For Insurers, There's More Than One ACA Court Case to Watch

Though the upcoming elections will shine a bright spotlight this year on the health care policy positions of lawmakers and the Trump administration, the courts will play just as big of a role — if not more — than politicians when it comes to shaping the future of the Affordable Care Act's health insurance reforms.

The biggest case at play is *Texas v. United States*, which challenges the validity of the entire ACA based on Congress' decision in 2017 to zero out the individual mandate's tax penalty (see infographic, p. 7). Because the elimination of the tax penalty makes the individual mandate unconstitutional, Republican-led states argue, the rest of the law also has to go, as it is "inseverable" from the mandate.

In a December 2018 ruling, U.S. District Court Judge Reed O'Connor sent shock waves through the health care sector by ruling that the entire ACA is in fact unconstitutional *(HPW 12/24/18, p. 1)*. At the request of Democratic attorneys general who had intervened in the case, the Fifth Circuit Court of Appeals then took up the case, ruling in December 2019 that while the mandate is unconstitutional, O'Connor needs to explain more clearly why he thinks that part of the law is inseverable from the rest of it *(HPW 12/23/19, p. 3)*.

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AHIP Launches Pilot to Field-Test Automated Prior Authorization

Health insurer trade group America's Health Insurance Plans (AHIP) is partnering with six insurers to test systems and technology designed to automate parts of the prior authorization process in a bid to develop best practices.

The initiative, which AHIP calls the Fast Prior Authorization Technology Highway, or Fast PATH, will run for six months, during which AHIP and its partners will collect data to be used for an evaluation of the processes and technology used. The trade group will attempt to determine how much money and time an automated system saves providers and insurers.

Still, the pilot — which will include around 100 providers per insurer — won't be large enough to make a measurable dent in prior authorization requirements for the vast majority of physicians, says Joe Paduda, principal with Health Strategy Associates LLC.

"The effect will be marginal at best as the small scale of this effort means physicians won't see a material impact," Paduda tells AIS Health. "However, it may earn some good will."

AHIP's Fast PATH program will help to determine what types of automation solutions have the potential for widespread adoption, and how much they might improve practice workflow. Insurers participating in Fast PATH will include: Anthem, Inc., Blue Shield of California, Cambia Health Solutions' affiliated health

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plans, Cigna Corp., Florida Blue and WellCare Health Plans, Inc.

RTI International, an independent non-profit research organization with expertise in health care, will perform the evaluation following the six-month project. Point of Care Partners, a management consulting firm, is serving as an expert adviser.

Both providers and insurers are affected by cumbersome manual prior authorization procedures, although they don't necessarily agree on what will fix the problems. Insurers say prior authorization is necessary and promotes good patient care, while physicians maintain prior authorization leads to worse outcomes in many cases.

In a search for common ground, AHIP joined with other industry stakeholders, including providers, two years ago to produce a consensus statement that laid out core principles for addressing prior authorization issues. Federal lawmakers also have considered requiring electronic prior authorization *(HPW 9/30/19, p. 4)*. AHIP and the Blue Cross Blue Shield Association have argued that Congress should step back from regulating prior authorization and other medical management tools, and let the industry determine what works.

Kate Berry, AHIP senior vice president of clinical innovation and strategic partnerships, says providers may be vocal about the problems, but insurers suffer from them too. "Typically, it is the providers who suffer from the burden of the back-and-forth of communications with the plans, but there is an equal number of phone calls and faxes on the other side," Berry tells AIS Health.

AHIP's Fast PATH pilot will address two common but critical prior authorization processes: approval for certain prescription medications and approval for medical and surgery procedures. The initiative will use technology from Surescripts for the prescription component of the project and from Availity, LLC, for the medical and surgical procedures authorization piece. Availity was founded in 2001 by Florida Blue and Humana Inc., and combined with Health Care Service Corp. unit The Health Information Network in 2006.

For the Surescripts component, physicians participating in the project will be able to immediately check for prior authorization requirements using their electronic health record (EHR) system and possibly choose an alternative treatment that doesn't require prior authorization.

Docs Can See Out-of-Pocket Costs

Providers opting to prescribe a medication that has a prior authorization requirement can submit the approval request immediately through the EHR. Finally, physicians will have access to the patient's out-of-pocket cost for each drug, so the patient will know what to expect to pay. This potentially could improve compliance, Berry says.

"The electronic prescribing piece is mainstream — 80% of providers are using electronic prescribing," Berry says. "But real time benefit check and the electronic prior authorization functionality is still at the early adoption phase, even with Surescripts." Availity is less widespread than that, she adds.

For the Availity component, doctors and surgeons can access a multipayer portal to simplify prior authorization requests that may be required for a surgery or another procedure.

The Availity portal allows for easier communication and faster approvals, AHIP says. When providers order a procedure for a patient, they'll know immediately whether prior authorization is required, and can submit the necessary information through the Availity portal to fulfill the request. The insurer will send a response through the portal, which includes a dashboard to manage all prior authorization requests.

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"Our goals for the project are to work across the whole ecosystem," Berry says. "So with a couple of technology providers, with a number of our health plan members and with their provider partners that are enabled with these technologies, we'll be able to actually look at multiple different workflows."

Planning work for the project has been underway for about 18 months, Berry says, adding that this process "is going to be a journey. It's not the kind of thing that can happen overnight." Although the insurers participating in the project may have more than 100 providers who already have deployed Surescripts and Availity technology via their EHRs, Berry says that asking the insurers to bring around 100 providers each into the project will give RTI a good data set with which to work. "A lot of people are focused on these issues, so we're sharing what we've learned so far," Berry says. Still, this project may enable AHIP to determine how much time and money are saved

Wall Street Analysts Are Mostly Bullish on 2020 Outlook for MCOs

Analysts from major financial institutions are cautiously optimistic about the value of managed care organization stocks during 2020, citing a more stable regulatory environment and rising revenues across the industry.

Over 2018 and 2019, markets were skeptical of MCOs' value due to regulatory turbulence in the form of attempts to roll back the Affordable Care Act, according to a Jefferies report by analysts David Windley and David Styblo.

In particular, they cite the *Texas v. United States* court case, in which 20 Republican attorneys general challenged the ACA's constitutionality based on the elimination of the individual mandate's tax penalty (see story, p. 1). In December 2018, U.S. District Court Judge Reed O'Connor ruled in favor of the plaintiffs, causing MCO stocks to drop. A subsequent appeals court ruling kicked most of the case back to O'Connor, which caused MCO stocks to rally but could prolong the litigation unless the Supreme Court agrees to take up the case.

But even before that ruling, MCO stocks had gained value in the latter half of the year. The Jefferies report cites setbacks in ACA repeal efforts and strong third-quarter earnings, particularly from UnitedHealth Group, as reasons why MCO stocks have, in the report's words, "outperformed the market by 20+ points."

Still, analysts have some misgivings about the recent rally. Citi analyst Ralph Giacobbe suggests that the late 2019 might correction might have pushed valuations too high, writing that "we continue to see value in the MCO space but acknowledge the significant rebound in stocks over the last couple months that begs the question of whether we have come too far too fast." Despite his skepticism, which is also based in part on the heated health care debate in the 2020 Democratic primary, Giacobbe does expect MCO revenue to continue to rise in the coming year.

So does a more optimistic Credit Suisse report by A.J. Rice, which predicts that "most MCOs anticipate a stable to modest pickup in medical costs for 2020."

Both the Credit Suisse and Citi reports anticipate stability, if not growth, in enrollment, citing growth in Medicare Advantage (MA) markets across the country.

Citi picked Cigna Corp. as its best investment bet for 2020, while the Credit Suisse report singled out UnitedHealth, Anthem, Inc., and Humana Inc. as strong bets for the coming year, saying that UnitedHealth and Anthem "offer strong visibility on their targeted annual EPS [earnings per share] growth over the next several years."

Credit Suisse's Humana endorsement comes from what the bank perceives to be the MCO's strong overall position, which the report says is "the most recession-resistant play among MCOs." The report also predicts Humana will increase its MA enrollment.

Jefferies named Centene Corp. as the best value in the space, anticipating higher revenues from the company's pending purchase of WellCare Health Plans, Inc. The report also predicts the company is likely to retain most of its Medicaid managed care contracts in 2020, and noted that earlier concerns about competition on the health insurance exchanges have abated.

Contact Giacobbe at ralph.giacobbe@citi.com, Rice at aj.rice@credit-suisse.com and the Jefferies analysts at dwindley@jefferies.com.

by Peter Johnson

by going from a manual preauthorization process of faxes and phone calls to an automated process, she says.

In addition, the project will help to pinpoint best practices in deploying these types of technology. "We're not going to tell everyone what technology to use, because there's lots of different solutions out there, but I think we'll have learnings that will be helpful to everyone as they continue to deploy these technologies," she adds.

AHIP went through an RFP process with vendors of automated prior authorization solutions, narrowing down the list from 18 companies that responded initially to the two vendors chosen, Berry says. Although multiple health insurers are deploying these solutions outside of AHIP's evaluation project, the insurers participating in Fast PATH already have relationships with Surescripts or Availity.

Anthem, Florida Blue and Cambia's health plans will help to test Availity's technology, while Blue Shield of California, Cigna and WellCare will help to test the Surescripts technology.

Both insurers and providers agree that prior authorization can be a time-consuming and frustrating process. Paduda says it's particularly burdensome for specialists in mental health, orthopedics, neurology and neurosurgery. "Different payers use different guidelines, and what is approved by one insurer may be rejected by others," he says.

As part of the January 2018 consensus statement on prior authorization, AHIP joined with the American Hospital Association, the American Medical Association, the American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association to make general statements on ways to improve the process.

In that statement, leaders of the groups pledged to work together to reduce burdensome requirements and improve channels of communication. They also pledged to accelerate industry adoption of national electronic standards for prior authorization and to improve transparency of formulary information and coverage restrictions at the point of care.

MCO Stock Performance, December 2019

	Closing Stock Price on 1/2/2020	December Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$204.94	4.1%	7.9%	$18.58
UnitedHealth Group	$292.50	4.6%	17.4%	$16.46
Anthem, Inc.	$300.87	4.7%	14.6%	$22.72
Commercial Mean		**4.4%**	**13.3%**	
MEDICARE				
Humana Inc.	$363.24	7.4%	26.8%	$18.64
Medicare Mean		**7.4%**	**26.8%**	
MEDICAID				
Centene Corp.	$61.88	2.8%	(46.3%)	$4.78
Molina Healthcare, Inc.	$133.37	(1.3%)	14.8%	$11.85
WellCare Health Plans, Inc.	$326.99	1.7%	38.5%	$17.07
Medicaid Mean		**1.1%**	**2.3%**	
Industry Mean		**3.4%**	**10.5%**	

*Estimates are based on analysts' consensus estimates for full-year 2020.

SOURCE: Bank of America Merrill Lynch.

Program May Have Some Shortfalls

An official at a provider trade group tells AIS Health that the AHIP pilot program does make an effort to improve automation, transparency and efficiency through the use of an electronic process. However, the official, who asked not to be identified by name, adds that the program falls well short of the joint consensus statement, particularly in provisions that encourage more selective use of prior authorizations and that encourage transparency and easy accessibility of prior authorization requirements.

The official also says the pilot's reliance on EHR portals appears to introduce an added step, or a possible technical hurdle for providers, because providers need EHR functionality in order to automate prior authorization.

Contact Berry via AHIP spokesperson Cathryn Donaldson at cdonaldson@ahip.org and Paduda at jpaduda@healthstrategyassoc.com. ✧

by Jane Anderson

ACA-Related Cases Abound

continued from p. 1

The attorneys general and House Democrats then petitioned the Supreme Court to take up the case on an expedited briefing schedule. On Jan. 6, the high court directed the plaintiffs and the Dept. of Justice — which has declined to defend the ACA — to respond to the request for an expedited briefing. Their response was due to the court after press time on Jan. 10.

While the ACA still stands as the litigation plays out, the uncertainty surrounding the *Texas v. United States* case has been felt, argues Deep Banerjee, an analyst at the credit rating firm Standard & Poor's. Even though the ACA exchange market has stabilized, "you still don't see some of the larger insurers jump back into the market," he tells AIS Health. "There are several reasons for it, obviously, but one of the reasons, we believe, is the fact that there is still a lot of legislative and legal uncertainty around the law."

To that end, other less-headline-grabbing cases are winding their way through the courts that also could have an impact on health insurers and the markets in which they operate, points out Katie Keith, a principal at Keith Policy Solutions, LLC and research professor at Georgetown University's Center on Health Insurance Reforms. According to Keith, who closely tracks such litigation for her Health Affairs blog, "Following the ACA," these include:

✦ ***Risk corridors litigation:*** *(Maine Community Health Options v. United States)*

What's the case about? In this case, Maine Community Health Options, Moda Health Plan, Blue Cross and Blue Shield of North Carolina, and Land of Lincoln Mutual Health Insurance Company contend that the federal government owes them $12 billion in payments from the ACA's temporary risk corridors program, which worked by requiring insurers with lower-than-expected claims to pay into the program, while plans with higher-than-expected claims received payment. During its three-year run, the risk corridors program took in far less than it paid out as insurers struggled with profitability. Insurers claim CMS must make up that shortfall, but the government contends that a provision in a 2015 omnibus spending bill, pushed through by Republicans, blocked the agency from doing just that.

Where does it stand? Mixed decisions in lower courts led insurers to petition the Supreme Court to take up the case, and oral arguments were held Dec. 10. Keith, who attended the hearing, tells AIS Health that there were "tough questions on both sides of it." On the one hand, Justice Samuel Alito seemed skeptical of insurers' arguments; but other justices were sympathetic, she says. In one memorable exchange, Justice Elena Kagan questioned why the government shouldn't have to adhere to the ACA statue requiring it to pay insurers, even though insurers must dutifully pay into the program. "There was almost like an energy shift in the room," Keith says. The Supreme Court could issue its decision as early as this spring. Because the case is more about statutory interpretation than politics, "we shouldn't expect that it [the court's decision] would break down along partisan lines or anything like that," Keith notes.

What's the impact? Whichever way the Supreme Court rules, it will apply to all outstanding risk corridors cases — of which there are many — Timothy Jost, a Washington and Lee University professor emeritus, previously told AIS Health *(HPW 12/2/19, p. 1)*. The $12 billion in risk corridors payments would be divided among those plaintiffs in the event of a favorable ruling for insurers. More broadly, though, a decision against the insurers could lead contractors of all stripes to wonder whether the government is a reliable business partner, Jost said.

✦ ***Risk Adjustment Litigation*** *(New Mexico Health Connections v. HHS)*

What's the case about? The ACA's risk adjustment program, which is permanent unlike the risk corridors and federal reinsurance programs, transfers payments from exchange insurers with lower-risk members to those with higher-risk members in order to spread out financial risk and protect health plans against adverse selection. But not all insurers approve: In fact, some Consumer Operated and Oriented Plans (CO-OPs) say the formula used to calculate payments disadvantages smaller, newer and lower-priced health plans, which, they argue, contributed to many CO-OPs' demise. That led to lawsuits that challenged the risk adjustment formula — in particular, HHS's use of a statewide average premium to calculate it.

Where does it stand? One such lawsuit, brought by the CO-OP New Mexico Health Connections (NMHC), received a favorable ruling at the district court level. Notably, that decision led the Trump administration to temporarily suspend about $10.4 billion in risk adjustment payments in 2018, which sparked outcry from insurers before HHS hastily issued a final rule to reinstate the payments *(HPW 7/30/18, p. 1)*. Fast forward to Dec. 31, and a three-judge panel of the 10th Circuit Court of Appeals overturned the ruling, saying that the use of a

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statewide average premium is not "arbitrary and capricious" after all *(HPW 1/6/20, p. 7)*.

What's the impact? Going forward, NMHC could ask for the case to be reheard by the entirety of the 10th Circuit, Keith says, or appeal directly to the Supreme Court. But it's also possible that the ruling will be the final word on risk adjustment litigation. Meanwhile, the latest ruling won't change the risk adjustment methodology as it stands now, since HHS already tweaked it in response to the lower court's decision in NMHC's favor. "In practice, the 10th Circuit ruling maintains the status quo — which means it won't have any immediate effect, at least not to my knowledge," University of Michigan law professor Nicholas Bagley tells AIS Health. Adds Keith: "It's a boring implication — it's maintenance of the status quo — but an important one for issuers."

✦ ***Cost-Sharing Reduction Payments Lawsuits*** *(Common Ground Healthcare Cooperative v. United States)*

What's the case about? The issue started with a 2016 federal court ruling, siding with the Republican-led House of Representatives, that found cost-sharing reduction (CSR) payments to insurers were improper because HHS doesn't have the authority to appropriate those funds. Based on that ruling, in October 2017, the Trump administration decided to stop reimbursing insurers for CSRs — which help low-income ACA exchange enrollees pay their out-of-pocket health care expenses — and insurers responded with lawsuits seeking billions of dollars from the government. Meanwhile, many state regulators worked with insurers to load the cost of the unpaid CSRs onto their silver-level plans, shielding consumers from sticker shock since advance premium tax credits rise in tandem with rates for those types of plans.

Where does it stand? So far, the courts have looked favorably on insurers' claims *(HPW 10/15/18, p. 4)*. In fact, Keith noted in a Nov. 22 blog post, insurers have won every CSR case that's been decided, including a class-action suit brought by 100 insurers (*Common Ground Healthcare Cooperative v. United States*). Because the statutes in question are structured similarly, the CSR cases are closely related to the risk corridors cases — which have been less successful in the courts — but the difference is, for the CSR suits, there is no budget-bill provision preventing the government from complying with its statutory obligation to pay insurers, Keith tells AIS Health. Four of the CSR cases have been appealed to the Federal Circuit, and oral arguments were held Jan. 9. During that hearing, Modern Healthcare reports, a three-judge panel expressed concern that insurers could profit from recouping CSR payments, since they've already been made whole by silver loading. Still, as Keith told AIS Health prior to the hearing, "Every court that I'm aware of that has looked at that so far at the district court level has found it doesn't matter if you silver loaded or not; you're still entitled to full CSR payments."

What's the impact? A lot of money is on the line, as the federal judge who decided the class-action lawsuit in favor of insurers found that they're owed nearly $1.6 billion for 2017 and 2018, Keith noted in an Oct. 25 post.

✦ ***Association Health Plans Lawsuit*** *(New York v. Dept. of Labor)*

What's the case about? In response to an executive order from the Trump administration, in mid-2018 the Dept. of Labor issued a final rule *(HPW 6/25/18, p. 1)* aimed at expanding access to association health plans (AHPs) as an alternative to ACA-compliant coverage. From a legal standpoint, the new regulation makes it far easier for associations based on common geography or industry to be considered a single, multi-employer plan under the Employee Retirement Income Security Act, Keith wrote in June 2018. Amid worries that the rule would damage the ACA-compliant market by siphoning off younger, healthier enrollees, 12 Democratic attorneys general challenged the rule in court.

Where does it stand? This past spring, a federal judge sided with the plaintiffs and struck down two key provisions of the new AHP rule *(HPW 4/8/19, p. 1)*. The Trump administration appealed, and a three-judge appeals court panel heard oral arguments regarding the case in mid-November. Keith, who listened to the hearing, tells AIS Health that the judges seemed likely to overturn the lower court's decision on AHPs. But the ruling might be a narrow one — concluding that the Dept. of Labor rule can stand and waiting to see how HHS responds, as that agency technically hasn't acted on it yet. "What that could mean is further litigation," Keith says.

What's the impact? For AHPs that have already formed, and for those trying to form, much is at stake as the D.C. Circuit Court of Appeals weighs its decision.

✦ ***Short-Term Health Plans Lawsuit*** *(Association for Community Affiliated Plans, et al v. U.S. Dept. of Treasury, et al)*

What's the case about? The final rule expanding access to short-term,

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limited duration health plans *(HPW 8/6/18, p. 1)* — issued in response to the same executive order as the AHP rule — reversed an Obama-era regulation that limited short-term plans to three months. Instead, they could cover individuals for up to 364 days and could be renewed up to 36 months, making them another alternative coverage option for those priced out of more robust, ACA-compliant plans. In this case, the court challenge came from the Association for Community Affiliated Plans (ACAP), which argued the new rule was driving membership declines in safety-net health plans *(HPW 7/29/19, p. 3)*.

Where does it stand? A district court judge rejected ACAP's argument in a July 2019 ruling, and like the AHP decision, the case was appealed to the D.C. Circuit Court of Appeals. Keith tells AIS Health that briefing will wrap up in February, with oral arguments expected around summertime. "So that one is still kind of hanging out there," she says of the short-term health plans lawsuit.

What's the impact? Banerjee, the S&P analyst, tells AIS Health that his firm will be "keeping an eye on" both the AHP and short-term plans litigation. That's not necessarily because either rule has had a big impact on the core ACA market, he cautions, "but it would be interesting to see how the courts rule on something like that, because there is always the potential of [such plans] becoming a larger part of the market."

See the petition for the Supreme Court to review *Texas v. United States* at https://bit.ly/2QHdKS5. Contact Keith at katie.keith@georgetown.edu, Bagley at nbagley@umich.edu and Banerjee via Jeff Sexton at jeff.sexton@spglobal.com. ✧

by Leslie Small

Texas v. United States: A Look Back

by Jinghong Chen

2018

Feb. — Lawsuit Filed

Twenty Republican attorneys general and governors, led by Texas, sued the federal government and argued that the Affordable Care Act's individual mandate is unconstitutional after Congress eliminated the tax penalty tied to the mandate in 2017 *(HPW 3/5/18, p.3)*. The suit also contended that because the rest of the ACA is inseverable from the individual mandate, the whole law should be struck down.

Mar.

April

May — Democrats Allowed to Intervene

Democratic state attorneys general from 16 states and the District of Columbia were allowed to intervene in the litigation and defend the ACA.

June — DOJ Revealed Position

The DOJ declined to defend the constitutionality of the individual mandate and some ACA provisions that protect people with preexisting conditions. But it argued that other provisions were severable from the mandate.

July

Aug.

Sept. — Oral Arguments Held

Judge Reed O'Connor of the federal district court in the Northern District of Texas held a three-hour hearing in which he questioned both the plaintiffs and defendants. His questions suggested he might strike down some or all of the ACA.

Oct.

Nov.

Dec. — Judge Ruled ACA Invalid

Judge O'Connor ruled that the entire ACA is unconstitutional *(HPW 12/24/18, p.1)*, as it is inseverable from the individual mandate.

2019

Jan. — Democrats Appealed

The DOJ and Democratic attorneys general appealed O'Connor's decision to the Fifth Circuit Court of Appeals in New Orleans. Four more Democratic attorneys general — from Colorado, Iowa, Michigan, and Nevada — and the U.S. House of Representatives were allowed to intervene and defend the ACA.

Feb.

Mar. — DOJ Changed Position

The DOJ changed its position to largely support the court decision that invalidated the entire ACA.

April

May

June

July — Oral Arguments Held

A panel of three judges held a hearing in which their questions for both sides of the case suggested they were unconvinced that the individual mandate was constitutional.

Dec. — Fifth Circuit Ruled

The Fifth Circuit Court of Appeals, in a 2-1 decision, ruled that the ACA's individual mandate is unconstitutional and ordered O'Connor to reconsider whether the rest of the law should also be struck down *(HPW 12/23/19, p.3)*.

2020

Jan. — Democrats Asked Supreme Court to Review

The Democratic-led House and Democratic attorneys general from 20 states asked the Supreme Court to hear the case before the court's current term ends in June. On Jan. 6, 2019, the Supreme Court ordered the DOJ and states challenging the ACA to file their response to Democrats' motion by Jan. 10.

SOURCE: Health Affairs, "Following the ACA." Visit https://bit.ly/2uozbhM.

News Briefs

✦ ***Startup health care company Bright Health said Jan. 8 that it signed an agreement to acquire the California-based, family-owned health plan Universal Care, which is doing business as Brand New Day.*** Brand New Day, which was founded in 1983, aims to improve health outcomes among vulnerable populations with complex health conditions by focusing on care management and patient-primary care relationships, according to a release from the companies. The transaction still requires regulatory approval and is expected to close this year; the companies did not disclose the dollar amount of the deal. Bright Health sells plans in the individual and Medicare Advantage markets in 12 states. Read more at https://prn.to/39TQEPk.

✦ ***Molina Healthcare, Inc. agreed to acquire NextLevel Health Partners, Inc., a Medicaid managed care insurer that serves about 50,000 members in Illinois' Cook County.*** Molina will pay approximately $50 million for NextLevel Health, which estimated that its premium revenue for 2019 is about $270 million. Pending regulatory approval, the transaction is expected to close in early 2020. "Acquiring NextLevel Health increases our footprint in the state of Illinois, enables us to scale our existing business platform, and provides additional operating cost leverage," said Pam Sanborn, president of Molina Healthcare of Illinois. "The existing base of acquired assets also provides Molina with expansion opportunities for our Medicare-Medicaid Plan (MMP) and Marketplace offerings." Visit https://bwnews.pr/2FyDDNn.

✦ ***WellCare Health Plans, Inc. and the National Institutes of Health (NIH) are teaming up with the behavioral economics company Wellth Inc. on a program aimed at helping at-risk Medicaid members in New York better manage their hypertension.*** The program, which will enroll at least 200 participants and run through August, employs Wellth's smartphone app to remind individuals to take their hypertension medication and reward them with gift cards for adopting healthy behaviors. NIH is funding the program and will study the results to learn "how mental accounting and targeted financial incentives that leverage behavioral economics can be used to design effective adherence interventions." Visit https://bit.ly/2FuZ6GP.

✦ ***Corporate Insight, a competitive intelligence firm, awarded "gold medals" to five health insurers as part of its fourth annual Health Plan Monitor awards,*** which highlight the most innovative online and mobile health insurance tools and features in 2019. Cigna Corp., Humana Inc., Oscar Health, Tufts Health Plan and UnitedHealthcare all won gold for their "extensive, robust online features that surpass Corporate Insight's criteria for service value and usability." Read more at https://prn.to/36Aecqt.

✦ ***Louisiana Dept. of Health Secretary Rebekah Gee, M.D., who helped the state expand Medicaid under Democratic Gov. John Bel Edwards and spearheaded the state's "Netflix-like" subscription model to increase access to hepatitis C drugs, resigned effective Jan. 31.*** In a press release dated Jan. 6, Edwards said Gee took a new job, which will be announced by her employer "at a later date." Gee's work on expanding Medicaid made her a prime target for Republican lawmakers in Louisiana, who were critical of the program's ballooning costs, noted an Associated Press article. Visit https://bit.ly/2FxJ8Md and https://bit.ly/2R1VsKd.

✦ ***Despite fears about the impact of the elimination of the individual mandate tax penalty in 2019, insurers in the individual market remain profitable, and the risk pool isn't significantly sicker than it was when the individual mandate was in effect.*** That's the conclusion of a new analysis from the Kaiser Family Foundation (KFF), which examined average premiums, claims, medical loss ratios, and gross margins from the third quarter of 2011 through third quarter 2019 in the individual insurance market. "While markets in some parts of the country, especially in rural areas, remain more fragile with fewer insurers and higher premiums than in urban areas, the individual market on average appears stable," KFF researchers concluded, noting that marketplace enrollment for 2020 has also held steady. (CMS's final enrollment figures for HealthCare.gov, released Jan. 8, tallied 8.3 million signups — down just slightly from 8.4 million in 2019). To learn more, visit https://bit.ly/2T7eYHK and https://go.cms.gov/35CuSMV.

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