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Ark. Ruling Leaves Little Path Forward for Work Requirements

A three-judge federal appeals court panel on Feb. 14 sided with a lower court and unanimously ruled that Arkansas' Medicaid work requirements are unlawful because they don't align with the chief objective of the Medicaid program — providing access to medical care to those who can't afford it. The ruling is likely to have implications for states, Medicaid managed care companies and other stakeholders beyond Arkansas' borders, policy and legal experts tell AIS Health.

"This certainly puts a damper on their plans," says Joan Alker, a research professor and executive director of the Georgetown Center for Children and Families, referring to other states' hopes to set up similar Medicaid waiver demonstrations. "This is a signature initiative of [CMS] Administrator [Seema] Verma, and the court decision could not have been more clear that this was an unacceptable overreach by the administration and that they had moved into territory where only Congress could go."

An opinion written by Republican-appointed Judge David Sentelle states that "we agree with the district court that the alternative objectives of better health outcomes and beneficiary independence" — which HHS cited as justification to approve Arkansas' demonstration program — "are not consistent with Medicaid."

continued on p. 6

Expanded Subsidies Help Grow California Exchange Enrollment

California's health insurance exchange, Covered California, expanded enrollment by 1.6% year over year for 2020, according to preliminary results released on Feb. 18 — figures that were highly anticipated since the state was testing new policies this year aimed at encouraging additional insurance signups.

Indeed, California attributed its enrollment growth to its newly expanded subsidies and robust marketing efforts by the state and payers. California now offers premium subsidies to people earning up to 600% of the federal poverty level (FPL), as the result of legislation passed last year and approved by Gov. Gavin Newsom, a Democrat. Under the Affordable Care Act (ACA), such subsidies typically only apply to people earning up to 400% of the FPL, unless a state chooses to provide funding for an expanded population.

California's move to replace the zeroed-out federal individual mandate with a state tax also likely played a role in driving new enrollment. New enrollments increased to 418,052 this year from 295,980 in 2019, a 41.2% increase.

The overall enrollment increase of 1.6% is also an improvement over 2019's open enrollment season, when both total enrollment and new enrollment declined year over year compared with 2018. However, 2020 renewals were lower than 2019 renewals by 8%.

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Also on Feb. 18, California announced it will hold a special enrollment period, from Feb. 18 to April 30, for those who were "unaware of the state penalty or the new financial help" offered by the state.

New Enrollees May Help Lower Costs

During a press call to discuss the enrollment figures, Covered California Executive Director Peter Lee said sustained enrollment and the continual addition of healthy enrollees is essential to keeping the risk pool manageable.

"It's critical to understand that consistency doesn't mean no change," Lee said. "The individual market is one marked by huge churn. About 40% of our insureds leave Covered California every year — the vast majority [of that group], over 85% — to get covered someplace else. Most of them get job-based coverage. Some age into Medicare. Some get other coverage. Keeping constant means getting new enrollment in, to make sure we get new people covered, and ensures a healthy risk mix."

Lee also argued that the large increase in new enrollments should improve the risk mix and lower costs over the long term, and he said 11 carriers lowered their premiums for the special enrollment period as a result of the strong initial enrollment figures.

Joel Ario, a health care consultant with Manatt Health, agrees that the large number of new enrollees should help keep costs low. Ario formerly served as insurance commissioner in Oregon and Pennsylvania, and was the first director of the HHS Office of Health Insurance Exchanges.

"In general, the new enrollees are going to be the people who didn't buy last year because they didn't really think they needed it immediately," Ario tells AIS Health. "The people who needed the health services immediately are always going to be the first ones in line. So when you get a big bump in new enrollees, you can expect it's likely to be people who were healthier in general. We'll see how that plays out in the numbers, but that's exactly what industry likes to see — a risk pool that has a substantial number of new entrants."

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As for the state's new individual mandate, Lee said the goal is to achieve universal coverage, rather than penalize residents. For 2020, the tax penalty for going without insurance is $695, according to Covered California's website.

"From the governor on down in California, we don't want to collect a dime in penalty dollars," Lee said. "The penalty's on the books, but no one wants the money. We want that to be the economic nudge to get people to get coverage."

Marketing Is Key to California's Strategy

According to Lee, Covered California considers marketing an essential part of its cost-control strategy.

"Our premiums are low in California because we invest in marketing," Lee said. "This fiscal year we expect to spend over $120 million through the year in marketing, outreach, support for agents and other programs. But just on advertising — paid work through TV, radio, social media — we will be spending about $47 million in this open enrollment period and in the special enrollment period, in which we plan to spend close to $7 million."

Lee also praised Covered California's and payers' efforts to raise public awareness of open enrollment, and the expanded subsidy levels in particular. Lee says that payers selling plans on the individual exchange boosted marketing by $11 million over 2019. Lee said the state will use $2 million out of that $11 million to fund plan-agnostic advertising for the extended open enrollment period.

Lee also took aim at the Trump administration's actions regarding the ACA. He criticized the administration's choices to cut marketing for the federal exchange and its backing of congressional Republicans' move to eliminate the

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individual mandate tax penalty, arguing that the administration's anti-ACA stance will drive up health care costs.

"Californians are seeing that by building on — instead of undercutting — the Affordable Care Act, they are directly benefiting from lower health care costs and more people being insured," Lee said.

Find more detailed enrollment data at https://bit.ly/38KN4GD. Contact Ario at jario@manatt.com. ✧

by Peter Johnson

As Health Care Costs Grow, Buyers Look 'Beyond Markets'

A new study by the Health Care Cost Institute (HCCI) found that the cost of health care and spending on health care both increased dramatically between the start of 2014 and the end of 2018. According to the study, price increases for provider services are the main reason why.

Annual spending per person increased 18.4% over the five-year period, from $4,978 to $5,892, the study said. After figures are adjusted for inflation, the cost of care per person increased by $610 over those five years. While utilization did increase, growing by 3.1% across all billing categories including drug benefits, provider price increases drove about 75% of spending growth — an average of $453 per person — when inflation is taken into account.

The study scrutinized deidentified commercial health insurance claims contributed by Aetna Inc., Humana Inc., Kaiser Permanente and UnitedHealthcare for 2014 through 2018.

John Hargraves, one of the study's authors, says that price increases are unambiguously the main driver of the spending increases, even though health care utilization increased across each of the four segments studied — inpatient care, outpatient care, professional services and pharmaceuticals.

"Prices are the driving factor when you're looking at the five-year trend. They've fairly consistently been the driver of spending increases for medical services as well as drugs," Hargraves tells AIS Health.

Utilization alone would not have increased prices so dramatically. As the study puts it, "the effect of the increase in utilization on total spending was higher than a similar increase would have been earlier in the period because price levels had increased steadily over the preceding four years."

Why Have Prices Increased So Much?

Though the study includes more detailed examinations of specific billing categories, such as average reimbursement amounts for outpatient radiology providers, Hargraves says HCCI is reluctant to draw conclusions about the reasons why providers have raised prices. Billing practices and documentation, he says, are too opaque to draw statistical conclusions. In fact, part of the study's methodology includes an effort to account for often-changing reimbursement coding, which makes like-for-like comparison of specific types of care difficult.

"The ways in which the negotiated price gets arrived at is a mystery," Hargraves says. "What we look at is the negotiated prices the payers do pay for services. When we look at price, we adjust for changes in case mix and intensity of services. Essentially, we're looking at the same services over time in terms of price."

Michael Thompson is more willing to draw conclusions. Thompson, the CEO of the National Alliance of Healthcare Purchaser Coalitions (AHPC), a trade group of employers and health care payers, says provider consolidation is perhaps the main reason that prices have escalated so quickly.

Purchasers Alliance Blames M&A

"We think consolidation is one of the biggest causes of cost increases in health care," Thompson tells AIS Health. "As providers have consolidated their negotiating power, there's been less ability for plans and employers to toe the line on cost. We're seeing increasingly costs get more out of whack market by market. It's become prevalent enough that purchasers are very concerned."

In many metropolitan markets, hospitals have consolidated into one or two mega-providers, allowing them to exercise effective monopoly or duopoly power. According to Thompson, this dynamic puts payers in a poor position when negotiating in-network agreements with inpatient providers, especially when combined with price opacity. Thompson cited a 2019 RAND Corp. study of hospital pricing as an influence on his analysis.

That study argued "transparency by itself is likely insufficient" to rein in prices, and suggested "employers may need state or federal policy interventions to rebalance negotiating leverage between hospitals and employer health plans. Such interventions could include placing limits on payments for out-of-network hospital care or applying insurance benefit design innovations to target high prices paid to providers and allowing employers to buy into Medicare or another public option that pays providers prices based on Medicare rates."

Thompson adds that "there is no doubt that private equity has looked for inefficiencies and weaknesses in

the market and looked to capitalize on them and accelerate trends that were there already."

Thompson says that outpatient providers have also contributed to price growth "on an unwarranted basis," a conclusion that dovetails with HCCI data. According to the study, spending on outpatient visits rose by 24% between 2014 and 2018, but utilization only increased by 1%.

For example, ambulatory surgery centers, a high-growth outpatient segment that offers lower costs than hospitals for routine and elective surgical procedures, still contributed to price increases. The cost of the average outpatient surgery reimbursement rose from $4,407 to $5,291 in 2018, according to HCCI.

Employers May Consider Price Controls

With prices escalating across the entire provider space, Thompson says his group has heard an increasing desire for radical solutions from frustrated members. Specifically, some employers could "respond favorably" to price controls or a public option, he says.

"I think that's where our growing interest in government intervention has started to play out, and we're more open to activities that may extend beyond markets. If health systems act like monopolies, they need to be regulated like utilities," Thompson says.

A Feb. 20 internal poll of AHPC members echoes Thompson's view. A press release detailing the results of the poll said "almost 34% of [health care] purchasers indicated that a Medicare public option could be a helpful reform for their employer health and wellbeing strategies, while another 29% were neutral." The release also said 80% of respondents considered hospital prices a "significant threat" to the affordability of employer-provided health coverage. Plus, 51.6% considered industry consolidation a threat to affordability.

"How could prices that are already way too high continue to go up at a pace higher than inflation?" Thompson says. "Well, it's because they don't know where the ceiling is. I believe that, if we can't make this market work, we're going to have to move beyond a market."

View HCCI's study at https://bit.ly/38KJ5K5. Contact Hargraves at jhargraves@healthcostinstitute.org and Thompson via Cary Conway at cary@conwaycommunication.com. ✧

by Peter Johnson

Pa. Moves Toward Independence From HealthCare.gov Platform

While Nevada is taking stock of its first Affordable Care Act (ACA) open enrollment period as a true state-based exchange *(HPW 2/10/20, p. 4)*, Pennsylvania is gearing up to follow in the silver state's footsteps and make its own break with HealthCare.gov.

Pennsylvania is one of three states — alongside New Jersey and New Mexico — that are planning an imminent transition from the federal health insurance enrollment platform to their own state-based exchange. Other states are reportedly considering similar moves now that the dust has long settled from some states' botched exchange rollouts in the early years of the ACA.

In the keystone state, the move will be the result of legislation Gov. Tom Wolf (D) signed this past July, which also cleared the way for a reinsurance program aimed at lowering individual market premiums. Zachary Sherman, who joined the Pennsylvania Health Insurance Exchange Authority in September as its new director after leading Rhode Island's exchange, tells AIS Health that the calculus Pennsylvania made was similar to what drove Nevada's transition. In short, the state believed it could derive more value from operating its own exchange, given that the federal government has twice increased the HealthCare.gov user fee (the fee will be 3% of individual market premiums this year).

"It was kind of a perfect combination of a lot of factors coming together to say, 'Could we, the Commonwealth of Pennsylvania, achieve the goals provided to us under the Affordable Care Act at a cheaper price, in a better way?'" Sherman says.

Savings Will Help Fund Reinsurance

In fact, by tapping the technology platform GetInsured — the same firm used by Nevada — Pennsylvania will be able to operate its own exchange for less money than it currently pays for HealthCare.gov, then use those savings to fund the state's share of a reinsurance program, Sherman says.

However, there are also benefits to operating a state-based exchange that aren't necessarily related to costs.

"When you have local control of the marketplace — its operations, its customer service, its technology, its outreach and marketing initiatives, its interactions and partnership with the local health insurance carriers — there's a lot of advantages to that, and all of them [are] in service to better access, better customer service [and] making sure that the products offered by the health plans are the right ones that fit the needs of the consumers you're trying to serve," Sherman says.

Pennsylvania's path to independence from HealthCare.gov will be a two-step process. Already, the state has shifted from relying exclusively on the federal government to operate its exchange to

becoming a state-based exchange using the federal platform (SBE-FP). That means during the open enrollment for health plans effective in 2020, which ran from Nov. 1 to Dec. 15, 2019, Pennsylvania continued to use HealthCare.gov's eligibility and enrollment platform, front-facing website and call center.

However, in accordance with the requirements to become an SBE-FP, the state took over open-enrollment outreach and marketing initiatives, as well as oversight of exchange navigator/assister and broker programs, Sherman explains.

Nevada was an SBE-FP since 2015 after a failed attempt to set up a completely state-controlled exchange, so it had its own marketing and outreach functions plus an established brand: the Silver State Health Insurance Exchange.

In contrast, "by law we are the Pennsylvania Health Insurance Exchange Authority," Sherman says. "That is not pithy or something you put on a logo, so we're working to name ourselves; that will be in service to the launch of the state-based exchange."

And that task is just one of many on Pennsylvania's plate as it prepares to transition to a full state-based exchange effective in 2021. Once the state's exchange has a new name, officials have to go about informing the public that they'll be visiting a new site to review and purchase coverage during the open enrollment period later this year.

"It's a fine line that we have to walk, and we have to get the message out at the right time," Sherman says. "People will be enrolled in coverage through HealthCare.gov through the end of this year, and you don't want to get out too early and create any undue and unnecessary confusion by saying, 'There's this new thing and you have to enroll through it.' We don't want anyone to lose their coverage because they're confused by the rollout of the state-based exchange for next year."

Thus, Pennsylvania is taking a two-phase approach — first promoting awareness about the coming change among existing HealthCare.gov customers, then a broader and more robust effort that Sherman describes as "more of your typical annual open enrollment marketing period."

State Must Coordinate With CMS, Payers

According to Sherman, that approach "requires pretty tight coordination between us and the federal government (CMS) to make sure that we make that transition for consumers as smooth as possible, as well as making sure that we're working very closely with our insurance partners to ensure they're helping mitigate any confusion and helping us drive consumers to the right place."

He describes Pennsylvania's exchange insurers as being "very supportive" of the move to a state-based exchange — including when the legislation authorizing the shift was being considered. "A number of insurers actually sit on our board of directors, so they have governance and fiduciary responsibility in a very direct way associated with the implementation and launch of this thing," Sherman adds.

Like Nevada did a year earlier, Pennsylvania is now working closely with insurance carriers to set up new electronic interactions between their systems and the state's nascent ex-

MCO Stock Performance, January 2020

	Closing Stock Price on 2/3/2020	January Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$193.19	(5.7%)	(5.7%)	$18.60
UnitedHealth Group	$272.80	(6.7%)	(6.7%)	$16.38
Anthem, Inc.	$264.88	(12.0%)	(12.0%)	$22.52
Commercial Mean		**(8.1%)**	**(8.1%)**	
MEDICARE				
Humana Inc.	$336.04	(7.5%)	(7.5%)	$18.61
Medicare Mean		**(7.5%)**	**(7.5%)**	
MEDICAID				
Centene Corp.	$62.62	1.2%	1.2%	$4.80
Molina Healthcare, Inc.	$123.71	(7.2%)	(7.2%)	$11.83
Medicaid Mean		**(3.0%)**	**(3.0%)**	
Industry Mean		**(6.3%)**	**(6.3%)**	

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

SOURCE: Bank of America Merrill Lynch.

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change. Sherman describes the process as involving "a considerable amount of operational, technological work, coordination [and] partnership" between various stakeholders.

For any states looking to make their own move to a state-based exchange, Sherman suggests that they focus not only on choosing the right technology platform, but also on hiring the necessary technical and operational resources to make the transition go smoothly. "You can hire a vendor to implement a thing," he explains, "but if you don't have the capacity or the time or the right people to tell them what's most important to your market and what you're trying to achieve in your state, they're not going to know what they don't know."

Contact Sherman at zsherman@pa.gov. ✧

by Leslie Small

Appeals Court Nixes Demo

continued from p. 1

"The text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage," Sentelle wrote. Therefore, HHS's approval of Arkansas' waiver was "arbitrary and capricious," he added.

According to data released by Arkansas' Dept. of Human Services, which the appeals court opinion cited, more than 18,000 people lost coverage between August and December 2018 as a result of the "Arkansas Works" program — or about 25% of those subject to the new requirements that Medicaid beneficiaries be employed, volunteer or meet other "community engagement" standards.

In addition to Arkansas' program, CMS has approved Medicaid waivers that include work requirements in Arizona, Indiana, Kentucky, Michigan, New Hampshire, Ohio, South Carolina, Utah and Wisconsin (see graphic, p. 7). Both Kentucky and New Hampshire's waiver programs have been struck down in court, and Kentucky has since abandoned its appeal after a Democratic governor, Andy Beshear, replaced Republican Matt Bevin.

Some States Suspended Programs

Arizona and Indiana voluntarily suspended their programs, Alker noted in a Feb. 14 blog post, while Michigan's has been challenged in court. The remaining states haven't yet been sued over their programs, but if they are, the cases will be reviewed by the same judge — James Boasberg — who struck down the Arkansas, Kentucky and New Hampshire waivers, Alker wrote. Meanwhile, an additional 10 states have applied for Medicaid waivers that include work requirements.

"I do think it [the appeals court ruling] will likely inhibit states from moving forward with work requirements waivers that have already been approved by CMS," Charles Luband, a partner in the health care practice of the law firm Dentons, tells AIS Health.

In theory, "it is possible that in approving new waivers, CMS could better articulate its decision to conform to what the courts specified as sort of the primary aim of the Medicaid program, which is to expand coverage," Luband says. "So it is possible that CMS will continue to accept requests for work requirements and may even continue to approve them, but if they do, CMS is going to have to try harder to meet the standard that's set out here."

CMS, for its part, is reviewing and evaluating the appeals court's opinion in order to determine next steps. In a statement after the ruling, Arkansas Gov. Asa Hutchinson (R) wrote: "The D.C. Court of Appeals ruled that the Medicaid Act does not permit a work requirement for able-bodied recipients even though one of the purposes of the Medicaid law is 'to help families be independent.' Arkansas implemented a work requirement in order to help recipients get worker training and job opportunities while receiving benefits. It is difficult to understand how this purpose is inconsistent with federal law."

Appeal to Supreme Court Is Floated

Hutchinson added that he hopes the Supreme Court will review the ruling in the case, *Gresham v. Azar* (No. 1:18-cv-01900).

However, Luband says that may not be likely. "The [Supreme] Court generally likes to take cases when there is a split between the circuits, and there's none here," he says. "There are other times that the court is likely to take up cases when it's sort of an issue of particular importance, but I don't see it right now."

In his statement, Hutchinson also argued that the court's ruling "undermines broad public support for expanded health care coverage for those struggling financially." Indeed, while the concept of Medicaid work requirements is "misguided," there is a concern that disallowing such programs may have other negative effects, says Jerry Vitti, founder and CEO of Healthcare Financial, Inc.

"Having work requirements gives red state governors and legislatures cover if they want to expand Medicaid," by allowing them to tie that expansion to conservative principles, he says. "Having that lever taken away could slow down expansion."

To date, 36 states and the District of Columbia have expanded Medicaid under the Affordable Care Act. If the remaining states opted for expansion, a total of 4.8 million nonelderly uninsured adults would be newly eligible for Medicaid, according to a Jan. 14 issue brief from the Kaiser Family Foundation.

Vitti also suggests that without the option to impose work requirements in Medicaid, some states might instead turn to a Healthy Adult Opportunity (HAO) demonstration as outlined in recent CMS guidance *(HPW 2/3/20, p. 3)*, which allows states to cap federal Medicaid funding, share in potential savings and test other program flexibilities. That could potentially affect more Medicaid enrollees in Arkansas, for example, than the 18,000 who lost coverage due to its work requirements, Vitti says.

But Luband points out that the legal precedent set by the *Gresham v. Azar* case could come into play if an HAO-inspired waiver program were ever challenged in court. CMS's guidance, he notes, is chiefly an invitation to states to use the existing section 1115 waiver structure to propose a certain kind of demonstration project. "And in that sense, it really needs to meet all of the same standards that are at issue in the Gresham case" when it comes to complying with the intent of the Medicaid statue, he says.

In fact, setting up work requirements for Medicaid beneficiaries is one of the program flexibilities that CMS encourages states to test through an HAO waiver, Luband notes.

What Are Implications for MCOs?

Of the seven states where Medicaid work requirements waivers have been approved but not struck down by the courts, all of them contract with managed care organizations to help provide benefits to enrollees, according to AIS's Directory of Health Plans. Regarding MCOs' views of Medicaid work requirements, "it's clear that they've had concerns about this," Alker says, though she adds that generally, they've expressed those concerns "more privately than publicly."

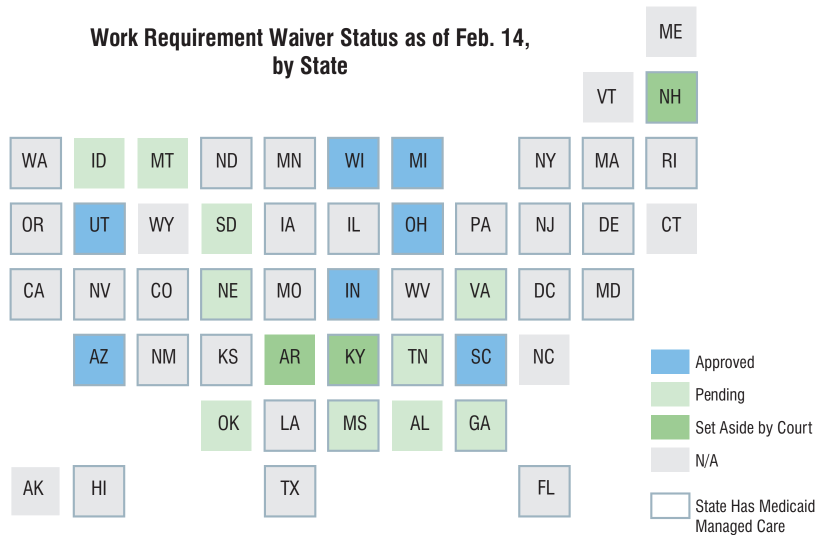
Alker also points to a Government Accountability Office (GAO) report that makes it clear managed care companies have played a role in states' work requirements programs — and they were compensated for it.

The report, published in October, audited Medicaid administrative spending in five states with approved work requirements waivers — Arkansas, Indiana, Kentucky, New Hampshire and Wisconsin — between August 2018 and September 2019. In addition to finding that federal oversight of work-requirements-related administrative spending needs improvement, GAO noted that Indiana, Kentucky and New Hampshire either required or planned to require MCOs to perform a number of activities to implement work requirements. Those tasks included providing information on options to satisfy work requirements, helping beneficiaries report compliance with work requirements,

Medicaid Work Requirements, at a Glance

by Jinghong Chen

The U.S. Court of Appeals for the District of Columbia Circuit recently upheld a lower court's stance blocking work requirements for Medicaid recipients in Arkansas. The three-judge panel found HHS's approval of the Arkansas Works program was "arbitrary and capricious." Medicaid work requirements in Kentucky and New Hampshire have also been set aside by the courts. Seven other states' work requirements were approved by HHS, while another 10 states' waivers are pending.



SOURCES: Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." Visit https://bit.ly/2vKrm6R. AIS's Directory of Health Plans, as of February 2020.

and providing referrals to state work requirement resources.

"To fund these activities, officials in these states said that they plan to increase their capitation payments" to MCOs, GAO wrote, adding that states receive at least a 90% federal matching rate for most of those payments under the ACA. "It is unclear, however, whether including these activities in capitation payments is allowable," GAO noted. Kentucky chose to rebid its managed care contracts after Beshear's decision to abandon the work requirements waiver *(HPW 2/2/20, p. 1)*.

View the court's opinion at https://bit.ly/2V6PGdO and the GAO report at https://bit.ly/2wzmstU. Contact Alker at jca25@georgetown.edu, Luband at charles.luband@dentons.com and Vitti via Joe Reblando at joe@joereblando.com. ✧

by Leslie Small

News Briefs

✦ ***The legal dispute between Cigna Corp. and Anthem, Inc. — concerning the $1.85 billion breakup fee tied to their failed attempt to combine — is not going to be resolved as soon as anticipated.*** Cigna Corp. CEO David Cordani said during the company's recent fourth-quarter earnings call that he expected a court ruling by the end of February, but a Feb. 14 Securities and Exchange Commission filing from Cigna revealed that the court issued a letter requesting that the parties in the case submit supplemental briefings. "As a result, Cigna Corporation no longer expects the court to issue its post-trial decision in this litigation before the end of February 2020," the filing states. It did not reveal when a decision now might be expected. View the filing at https://bit.ly/2V7qLXI.

✦ ***While many employers are interested in taking advantage of the new federal rule that gives them more freedom to offer pretax reimbursement to employees who buy their own health coverage, uptake has been slow.*** Such is the conclusion of a Modern Healthcare article, which included input from third-party administrators, brokers and health insurers about health reimbursement arrangements (HRAs). Meanwhile, a new report on qualified small employer HRAs (which existed before the new regulations) found that the allowance caps set by the Internal Revenue Service for QSHRAs appear to be at a reasonable level. The report, from the software company PeopleKeep, found just 18% of single employees used up their total allowed funds in 2019 and 19% of families used their allowed funds, according to an article from Benefits Pro. Visit https://bit.ly/39G0Ha2 and https://bit.ly/2P7EXMo.

✦ ***On Feb. 16, New Mexico's state House passed a Democratic proposal that would levy a tax on health insurers, but the measure then stalled in a Senate committee, according to the NM Political Report.*** The bill, which will now have to wait until the next legislative session, would replace the federal health insurer fee that was repealed in December 2019 with a similar state tax. The resulting revenue, estimated to be $125 million annually by the state's budget ombudsman, would be directed toward a fund that could subsidize insurance premiums. Read more at https://bit.ly/37IwjKN and https://bit.ly/39Ptx7Z.

✦ ***A study by the Centers for Disease Control and Prevention concluded that, in 2018, 12.4% of seniors on traditional Medicare and 12.3% of seniors using a combination of Medicare and Medicaid were members of families struggling to pay medical bills.*** Meanwhile, 8.3% of seniors enrolled in Medicare Advantage (MA) plans have trouble with medical costs. Both groups were more likely to struggle with health costs than seniors with non-MA private insurance, of which 5.6% have medical cost challenges. Read the study at https://bit.ly/32mT6ed.

✦ ***Louisiana Gov. John Bel Edwards (D) appointed Courtney Phillips to lead the state Dept. of Health (LDH).*** Phillips previously served as executive commissioner of Texas's Health and Human Services department, and the chief executive of Nebraska's Dept. of Health and Human Services. LDH recently re-bid its Medicaid contracts after the state's lead procurement official identified flaws in the initial bid process *(HPW 2/3/20, p. 1)*. Philips replaces Rebekah Gee, M.D., who resigned Jan. 31. Visit https://bit.ly/37JfD5J.

✦ ***CORRECTION:*** The Feb. 10 issue of Health Plan Weekly incorrectly stated that all Blue Cross Blue Shield affiliates were participating in a partnership with Civica Rx to manufacture generic drugs. As of Feb. 17, 18 regional Blues have joined the agreement.

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