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Health Insurers Hail SCOTUS Ruling in Risk Corridors Case

The Supreme Court's near-unanimous decision on April 27 to award health insurers $12 billion in unpaid risk corridors funding was certainly a win for the industry, but it might not be as big of a windfall for insurers as it may seem, experts tell AIS Health.

The risk corridors program was part of the Affordable Care Act's "three Rs" — alongside risk adjustment and reinsurance — which were meant to stabilize the individual market in the law's early years. With risk corridors, the government shares in insurers' losses and profits, so health plans with lower-than-expected claims paid into the program while plans with higher-than-expected claims received payment.

During its three-year existence, the risk corridors program took in far less than it paid out as many health insurers sustained financial losses. In dozens of lawsuits, including one class-action suit involving more than 100 insurers, plaintiffs claimed that CMS must make up the $12 billion shortfall. But the government resisted, saying a provision in the 2015 omnibus spending bill effectively blocks CMS from doing so. Split decisions in the lower courts resulted in one consolidated case, *Maine Community Health Options v. United States*, reaching the Supreme Court, where justices were won over by health plans' arguments.

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Anthem, Cigna Beat MLR Estimates, Prep for Enrollment Shift

Anthem, Inc., and Cigna Corp. both reported slightly better-than-expected medical loss ratios (MLRs) as part of their first-quarter 2020 earnings, in part due to delays in elective procedures resulting from the COVID-19 pandemic. Both insurers also reaffirmed their overall earnings-per-share (EPS) guidance for 2020.

But like UnitedHealth Group, which reported its own first quarter earnings on April 15 *(HPW 4/20/20, p. 3)*, the insurers warned that MLRs may tick up later this year. In addition, they predicted that the impact of COVID-19 may lead to significant shifts in enrollment, as workers who are laid off shift to Medicaid or to the Affordable Care Act exchanges.

Cigna reported an MLR of 78.3%, compared with analysts' consensus estimate of 79.3%, Citi analyst Ralph Giacobbe pointed out in an April 30 investor note. Cigna is maintaining its 2020 guidance for EPS and revenue, while dropping its outlooks for MLR and other specific financial metrics.

Meanwhile, Anthem posted a first-quarter MLR of 84.2%, slightly better than the consensus estimate of 84.3%, "likely aided to a limited degree by COVID-19 toward the latter part of the quarter," Giacobbe wrote in an April 29 investor note. "Membership fell below consensus within the commercial risk segment, but perhaps better than feared given unemployment backdrop."

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For Anthem, "data shows lower procedures, but not yet lower membership," Jefferies equities analyst David Windley wrote in an April 29 investor note. "We think that's inevitable and maintain our hold." First-quarter EPS and MLR were in line both with consensus and Anthem's expectations, he said.

Anthem's second-quarter MLR "should be historically low" due to delayed procedures, but that will be offset by a rebound in volumes, buyback suspension and low net interest/investment income during the second half of the year, Windley wrote.

At the same time, Medicaid and exchange enrollment can offset expected commercial group disenrollment, "but not the full rev[enue] and margin hit," he added. "Anthem has the most exposure among peers to rising unemployment due to its relatively larger commercial group risk book. Management started observing in-group deterioration during the second half of April, and we would expect this to worsen. Anthem's Medicaid book (and to a lesser extent, HIX) helps mitigate commercial enrollment losses."

Anthem management indicated that 40% to 50% of disenrolled commercial lives will move to Medicaid, while 30% will move into individual health insurance, Windley wrote. "However, this creates an unfavorable mix," with lower per-member per-month payments, especially in Medicaid, and a move to lower-margin products, he noted.

"Anthem noted that if a fully insured commercial member transitions to Medicaid/Exchanges, it would create a headwind, all other things being equal, as fully insured operating margins are in the mid-to-high single digits, while Medicaid is 2-4% and individual ACA is 3-5%," added Credit Suisse analyst A.J. Rice in an April 30 investor note. "Commercial ASO moving into Medicaid or individual ACA could be a positive for the company. Additionally, Anthem noted that there has not been a meaningful increase in COBRA thus far."

New members coming into Medicaid from commercial contracts might be slightly healthier than the current Medicaid population, Rice said, which could help if Anthem is faced with Medicaid rate cuts due to states' pandemic-related budget shortfalls.

On the pharmacy side, Anthem's new IngenioRx PBM posted a strong start with quarterly earnings of $349 million, well above the $275 million to $300 million earnings Windley said he expected.

"Overall, [Anthem's] results speak to MCOs' ability to manage through COVID crisis with cushion from depressed non-COVID utilization," observed Evercore ISI analyst Michael Newshel in an April 29 investor note.

Express Scripts Performs Well

Meanwhile, Cigna outperformed in its health services segment, which includes its Express Scripts PBM business, and its integrated medical segment. Express Scripts benefited from higher prescription volume and margins in the quarter, which likely included some early refills due to COVID-19, Newshel said in an April 30 investor note.

During their earnings conference calls, both insurers outlined multiple ways they are responding to the COVID-19 crisis with additional funding and support where it is needed, but they warned of potential unknown effects ahead.

"The impact of COVID-19 is still developing," Cigna President and CEO David Cordani said April 30. "We clearly see headwinds driven by the recession that it's causing, including, for example, disenrollment within our commercial customers, both in our integrated medical business [and] our health service business, as well as some pressure in our group disabili-

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ty business. As for medical costs, we expect somewhat offsetting impacts from elevated COVID-19 claims costs and lower medical costs from deferred procedures. We fully recognize this as a dynamic environment. However, we expect the strength of our first quarter to drive us to another strong year for revenue, earnings and free cash flow."

'Unprecedented' Lives Shift Is Likely

Anthem President and CEO Gail Boudreaux said April 29 that "the economic impacts of the crisis may also drive an unprecedented shift in consumers from the employer market into our Medicaid and ACA [Affordable Care Act] segments."

"We are quickly reallocating resources as may be needed to meet these potential challenges," she added. "In the small-group market, a segment especially vulnerable to disruption, we are proactively identifying groups at risk and providing more affordable product offerings. We're helping displaced members find coverage in the individual marketplace or in Medicaid."

Overall, Anthem earned $5.94 per share in the first quarter. Operating revenue was $29.4 billion, up $5.1 billion, or 20.7%, versus the prior year. The revenue jump was driven by pharmacy product revenue related to the launch of IngenioRx, plus higher premium revenue from rate increases to cover overall cost trend (including the return of the health insurance tax in 2020), and membership growth.

Cigna reported earnings of $3.15 per share on operating income of $1.8 billion, a 20% jump from the first quarter of 2019. Per-share operating income growth of 20% year-over-year reflects strong earnings contributions led by the company's health services, integrated medical and international markets segments, Cigna said.

View Cigna's earnings release at https://bit.ly/3aKsaYg and Anthem's release at https://bit.ly/2YmiDUv. Contact Newshel at michael.newshel@evercoreisi.com, Giacobbe at ralph.giacobbe@investmentresearch.citi.com, Windley at dwindley@jefferies.com and Rice at aj.rice@credit-suisse.com. ✧

by Jane Anderson

Humana, Centene Maintain 2020 Guidance Despite Crisis

Humana Inc. and Centene Corp. are both maintaining their 2020 earnings outlook despite the emergence of the COVID-19 pandemic and economic contraction at the end of the first quarter. Centene's earnings fell short of the Wall Street consensus projection for the first quarter, while Humana's earnings exceeded forecasts.

Humana's revenues increased to $18.9 billion, compared with $16.1 billion in the first quarter of 2019, and it reported $5.40 in adjusted earnings per share (EPS), beating the Wall Street consensus of $4.66 adjusted EPS. Centene's first quarter revenues increased 41% year-over-year to $26 billion, up from $18.4 billion, and it reported an adjusted EPS of $0.86. Centene fell short of the consensus with $0.99 adjusted EPS. Both insurers affirmed their projections for the end of the year, with Humana forecasting adjusted EPS of $18.25 to $18.75 and Centene $4.56 to $4.76.

But both companies warned that the pandemic and recession presented substantial risk, and noted that utilization could spike in the latter half of 2020 due to pent-up demand. They also reported that utilization dropped toward the end of the first quarter, and anticipated the same result for the second. Government officials across the country have suspended elective procedures, and patients have avoided trips to medical facilities to stay isolated at home. Executives from Centene and Humana anticipate utilization to return to normal levels, if not higher, as shelter-in-place orders and elective procedure stoppages are lifted.

Humana Has Strong Growth Opportunity

Analysts were cautiously optimistic about both firms' outlook for the rest of the year. "We believe that Humana boasts a compelling growth opportunity in the increasingly appealing [Medicare Advantage] market. Furthermore, the company also has an opportunity to drive margins given a potentially more favorable reimbursement environment and the maturation of its high-growth member base," Oppenheimer's Michael Wiederhorn wrote in an April 29 note.

Taking advantage of its strong position at the beginning of the year, Humana increased its cash on hand to more than $2.3 billion in anticipation of a higher volume of claims.

Despite Centene's seemingly less impressive results, analysts were positive or neutral about the firm's first-quarter performance.

Windley wrote in an April 28 note regarding Centene that "we aren't expecting ridiculously low 2Q [medical loss ratios] as management guards against an increase in utilization and claims severity. That said, the delay in procedures and incremental revenue from higher Medicaid/[health exchange] membership helps absorb new headwinds such as slower WellCare synergy capture, COVID-19 treatment costs, and adverse impacts on investment income/interest expense."

Though Centene's results were less robust than Humana's, the company indicated it is in a strong position for the remainder of the year. The company has a large Medicaid

managed care book, and Medicaid enrollment is certain to spike due to layoffs caused by the COVID-19 pandemic *(HPW 3/23/20, p. 1)*. "The additional membership will be a tailwind to 2020 earnings, particularly in our Medicaid business, although we expect normalization of enrollment during the second half of the year as the economic recovery progresses," said Centene Chief Financial Officer Jeffrey Schwaneke during an earnings call.

WellCare Deal Faced Obstacles

Centene's ongoing absorption of WellCare Health Plans, Inc., a deal which closed in January, was a drag on earnings. The integration process faces a major regulatory obstacle in Georgia, as the state delayed WellCare's integration with Centene's state subsidiary over concerns about the quality of the resulting provider network. During the earnings call, Nephron Research analyst Joshua Raskin asked executives when the firm expected to see return from the transaction's synergies. Neither Schwaneke nor CEO Michael Neidorff gave a timeline.

"[Regarding] delay in WellCare synergies, again, I think we've mentioned in the past that the WellCare transaction was effectively break-even without the share repurchase. I think we'd still be at break-even if you would include the share repurchase this year. So I think, from a transaction perspective, that can give you a relative size on the synergy shift. And again, we're still trying to capture those synergies," Neidorff said.

Read Humana's press release at https://bit.ly/3bRUwRJ and a transcript of the earnings call at https://bit.ly/2zLZJML. Read Centene's release at https://bit.ly/2yhulFx and a transcript of its earnings call at https://bit.ly/2VOBiqA. ✧

by Peter Johnson

Insurers Win Risk Corridors Case

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As Justice Sonia Sotomayor wrote for the 8-1 majority, the court's holdings "reflect a principle as old as the Nation itself: The Government should honor its obligations."

"I've always found it difficult to believe that the insurers didn't have a good constitutional basis to demand payment," Jeff Myers, senior vice president of reimbursement strategy and market access for Catalyst Healthcare Consulting, tells AIS Health. In fact, "it boggles the mind that the appeals court could suggest that statutory law didn't require the government to pay," he adds.

Insurers Scored 'Resounding Win'

Katie Keith, who attended the Supreme Court's Dec. 10 hearing on the case, shares a similar view.

"My sense from oral argument is the justices seemed pretty sympathetic to the insurers' arguments," says Keith, research professor at Georgetown University's Center on Health Insurance Reforms and principal at Keith Policy Solutions, LLC. "I was surprised at 8-1, but I'm pretty much surprised by a vote of 8-1 on anything from this court," Keith adds. "So that was sort of interesting and a very resounding win."

"We appreciate that today's Supreme Court 8-1 decision ensures that the federal government honors the obligations it made for services the private sector already delivered," Matt Eyles, president and CEO of America's Health Insurance Plans, wrote in a statement regarding the ruling.

Added Margaret Murray, CEO of the Association for Community Affiliated Plans: "It's absurd to ask health plans — or anyone else doing business with the United States government — to price in the notion that Congress might arbitrarily walk away from commitments it makes in Federal law. We're relieved the Supreme Court agrees."

Yet while the decision may be good news for the insurers that sued, Myers says he isn't so sure the risk corridors program was set up very well in the first place.

"In essence, because the design wasn't particularly well done, you're going to have a lot of money transferred from the taxpayer — and frankly, plans that were offering copper plans and other well-managed plans — to plans that had lots of benefits and arguably took on more risk," he says. "So I think ultimately, most of this money is going to go to the Blue Cross [and Blue Shield] plans, which have never been particularly financially efficient in the individual marketplace."

Will This Jeopardize a Bailout?

Another possible concern is that the $12 billion judgment in some insurers' favor will impact the industry's ability to receive funding from the government to stem any losses related to the COVID-19 pandemic and stabilize the insurance markets.

"I think the perception could hurt them," Keith says. "It is a big number; $12 billion sounds like a lot."

Yet she points out that the court's ruling concerned payments from the ACA's temporary risk corridors program from 2014 to 2016, so "it would be a mistake to think that all of this money is going towards companies that are offering coverage now."

Ultimately, the $12 billion going to some insurers "would be a very poor substitute for some kind of broader, individual market stabilization from Congress," she says.

When it comes to the current individual market, Keith says the one

potential implication of the risk corridors ruling surrounds how it will affect insurers' medical loss ratios (MLRs). Under the ACA, individual market insurers must spend at least 80% of their premium income on medical care, and they must issue rebates to members if the percentage dips below that.

HHS will probably issue guidance that outlines how the $12 billion judgment will affect MLRs, Keith says, as it's not yet clear whether the funds will affect MLR rebate calculations for 2020. Insurers that participate in the individual, small-group and large-group markets are projected to issue a record high $2.7 billion in MLR rebates to their customers this year *(HPW 4/27/20, p. 7)*.

But Keith says it is clear that the risk corridors ruling doesn't necessarily mean the Supreme Court will rule in favor of the ACA in a case (*Texas v. U.S.*) challenging the entirety of the law, which is slated for oral arguments later this year.

"I would be wary of looking at this as like a pro-ACA decision," she says, pointing out that the case was less about ideology and more about statutory interpretation and appropriations law.

"The way I think about this case is it happened to be about the ACA, but it could've been about any other issue."

Contact Keith at kmk82@georgetown.edu and Myers via Joe Reblando at joe@joereblando.com.

View the Supreme Court's opinion at https://bit.ly/2VS49KN. ✧

by Leslie Small

U.S. Chamber of Commerce Backs Temporary Health Insurance Subsidies

In a notable reversal, U.S. Chamber of Commerce joined America's Health Insurance Plans (AHIP) and the American Hospital Association (AHA) in supporting broad — but temporary — federal involvement in health insurance markets during the COVID-19 pandemic.

In an April 28 letter to congressional leadership, the groups endorsed several policies designed to help preserve health insurance coverage, saying Congress should consider them in "the next round of legislation to overcome COVID-19." The five specific policies the letter called for are:

- ***Subsidies to employers for health benefits;***
- ***Full federal payment of employers' share of COBRA benefits;***
- ***Expanded use of health savings accounts;***
- ***A special enrollment period for health exchanges, including HealthCare.gov; and***
- ***Subsidies to help higher earnings buy health exchange plans.***

Previously, AHIP and the Blue Cross Blue Shield Association sent a letter to Congress publicly backing many of those same policies *(HPW 4/6/20, p. 1)*.

Dan Mendelson, the founder of consulting firm Avalere Health, says the Chamber's backing of these policies would give political cover to Republican members of Congress to do the same. The Chamber was one of the most prominent lobbying groups to oppose the Affordable Care Act and has close institutional ties to the Republican Party.

"To have the Chamber backing [those policies] is definitely meaningful, given the political leanings of the membership of the Chamber," Mendelson tells AIS Health.

Still, in a conference call discussing the letter with the press, Neil Bradley, the Chamber's chief strategy officer, emphasized the group's new position is limited to the duration of the crisis.

"It's got to be timely, temporary and targeted," Bradley said. "No one is trying to rewrite long-term policy here. We're trying to address immediate needs. As we've seen with a whole host of other programs, it's important to be able to leverage existing delivery mechanisms in order to provide aid when it's needed in a timely fashion."

Of the five policies mentioned in the letter, Mendelson says COBRA subsidies are most likely to pass Congress. House Democrats have already proposed a bill that would have the government pay all of employers' COBRA costs, and Mendelson suggests the Chamber's endorsement will help Republicans support it.

"Given a choice, most members of Congress would prefer to see a preservation of private insurance as opposed to having states assume Medicaid liability," Mendelson says.

Read the letter at https://bit.ly/3f66Wr5. Contact Mendelson via Liz Moore at lmoore@avalere.com.

by Peter Johnson

Key Financial Data for Leading Health Plans — Fourth Quarter 2019 (Year-to-Date)

Health Plan Weekly subscribers can access more health plan financial data — including year-over-year comparisons of leading health plans' net income, premium revenue, medical loss ratios and net margins. Just email support@aishealth.com to request spreadsheets for current and past quarters.

Company	Premium Revenue	Hospital/ Medical Costs	Pharmacy Costs	Total Medical Costs	Medical Loss Ratio	Administrative Costs	Admin. Expense Ratio	Net Income (Loss)	Net Margin
Aetna	$63,031,000,000	$53,092,000,000	$0	$53,092,000,000	84.23%	$12,873,000,000	20.42%	$3,639,000,000	5.77%
Anthem, Inc.	$94,173,000,000	$81,786,000,000	$0	$81,786,000,000	86.85%	$13,364,000,000	14.19%	$4,807,000,000	5.10%
Arkansas BCBS	$2,389,476,420	$1,148,868,460	$464,236,277	$1,919,407,994	80.33%	$264,507,096	11.07%	$84,545,585	3.54%
BCBS of Alabama	$6,105,991,939	$2,840,037,026	$1,266,327,854	$5,491,279,299	89.93%	$340,230,921	5.57%	$403,118,282	6.60%
BCBS of Arizona	$2,330,735,393	$1,124,110,671	$337,438,991	$1,835,088,926	78.73%	$134,809,413	5.78%	$186,761,027	8.01%
BCBS of Florida, Inc.	$11,483,533,755	$5,862,749,086	$1,941,362,832	$9,185,203,066	79.99%	$997,257,342	8.68%	$775,347,539	6.75%
BCBS of Kansas City	$1,608,092,955	$1,131,846,702	$152,067,858	$1,331,696,246	82.81%	$185,614,011	11.54%	$49,360,409	3.07%
BCBS of Louisiana	$2,377,426,089	$1,580,255,101	$483,094,130	$2,070,575,606	87.09%	$254,501,290	10.70%	$61,560,685	2.59%
BCBS of Massachusetts	$8,383,999,245	$5,487,259,135	$1,246,426,246	$7,463,813,083	89.02%	$505,550,902	6.03%	$214,916,376	2.56%
BCBS of Michigan	$13,519,509,781	$9,168,849,839	$1,550,978,673	$11,534,251,589	85.32%	$1,338,617,251	9.90%	$980,089,754	7.25%
BCBS of Minnesota	$6,171,993,110	$4,279,763,767	$702,587,230	$5,444,967,238	88.22%	$487,676,709	7.90%	($69,854,542)	-1.13%
BCBS of Nebraska	$1,573,655,583	$1,052,331,938	$231,516,903	$1,314,573,707	83.54%	$131,533,885	8.36%	$916,124	0.06%
BCBS of North Carolina	$8,919,232,168	$4,846,543,812	$1,493,749,919	$7,355,091,559	82.46%	$964,321,570	10.81%	$365,904,046	4.10%
BCBS of Rhode Island	$1,696,205,986	$958,933,390	$205,098,168	$1,435,820,144	84.65%	$170,198,332	10.03%	$68,833,715	4.06%
BCBS of South Carolina	$4,623,136,702	$2,002,337,665	$840,707,247	$3,798,451,606	82.16%	$457,929,868	9.91%	$302,013,055	6.53%
BCBS of Tennessee	$5,205,541,851	$2,882,772,155	$736,258,065	$4,317,314,599	82.94%	$348,403,024	6.69%	$234,197,335	4.50%
Blue Shield of California	$18,827,867,000	$13,060,653,000	$2,603,337,000	$15,663,990,000	83.20%	$2,523,022,000	13.40%	$573,046,000	3.04%
Capital Blue Cross	$948,782,346	$647,585,336	$37,987,367	$885,327,029	93.31%	$88,766,863	9.36%	($16,673,103)	-1.76%
CareFirst BCBS	$8,948,342,678	$4,887,888,457	$1,878,510,741	$7,632,558,522	85.30%	$1,027,898,037	11.49%	$382,761,843	4.28%
CareSource	$9,458,631,259	$4,011,604,952	$1,713,294,928	$8,282,294,000	87.56%	$1,133,961,772	11.99%	$138,057,628	1.46%
Centene Corp.	$67,439,000,000	$58,862,000,000	$0	$58,862,000,000	87.28%	$6,533,000,000	9.69%	$1,321,000,000	1.96%
Cigna Corp.	$36,041,000,000	$24,319,000,000	$0	$24,319,000,000	67.48%	$8,369,000,000	23.22%	$3,904,000,000	10.83%
EmblemHealth, Inc.	$7,071,495,088	$5,086,757,733	$771,221,156	$6,163,321,528	87.16%	$745,834,267	10.55%	$17,213,993	0.24%
Harvard Pilgrim Health Care	$2,871,439,292	$1,841,861,428	$375,155,173	$2,439,802,861	84.97%	$322,376,590	11.23%	$44,863,974	1.56%
Hawaii Medical Service Assn.	$3,507,439,181	$2,724,254,040	$374,080,103	$3,175,461,115	90.54%	$211,010,162	6.02%	$62,717,969	1.79%
Health Alliance Plan of Michigan	$1,640,196,935	$1,171,798,962	$126,815,314	$1,446,394,670	88.18%	$164,424,963	10.02%	$28,193,555	1.72%
Health Care Service Corp.	$39,029,756,985	$26,149,243,558	$5,311,799,210	$31,696,809,241	81.21%	$3,286,644,877	8.42%	$2,270,159,683	5.82%

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Healthfirst	$3,031,347,098	$2,104,434,387	$166,526,616	$2,608,684,363	86.06%	$302,725,951	9.99%	$25,362,107	0.84%
HealthNow New York, Inc.	$2,834,397,358	$1,656,305,894	$435,770,565	$2,419,074,172	85.35%	$250,600,533	8.84%	$55,125,846	1.94%
HealthPartners	$1,384,736,070	$1,847,583,692	$227,247,429	$2,207,040,799	159.38%	$147,469,901	10.65%	($64,156,368)	-4.63%
Highmark Health	$9,475,266,847	$4,492,444,302	$1,077,248,193	$5,682,107,562	59.97%	$822,171,444	8.68%	$85,677,330	0.90%
Humana, Inc.	$62,948,000,000	$53,857,000,000	$0	$53,857,000,000	85.56%	$7,381,000,000	11.73%	$2,707,000,000	4.30%
Independence Blue Cross	$13,321,993,819	$10,420,786,471	$600,206,118	$11,920,606,934	89.48%	$853,482,880	6.41%	$368,940,939	2.77%
Kaiser Permanente	$20,023,304,291	$8,834,172,046	$2,408,716,323	$19,006,788,434	94.92%	$1,174,242,206	5.86%	$251,316,157	1.26%
Lifetime Healthcare Companies/ Excellus BCBS	$5,964,621,367	$3,665,788,004	$987,526,629	$5,261,144,235	88.21%	$420,448,637	7.05%	$170,769,402	2.86%
Medica	$4,542,371,804	$2,967,764,904	$386,253,518	$3,755,768,183	82.68%	$414,163,680	9.12%	$443,726,871	9.77%
Medical Mutual of Ohio	$2,745,478,625	$1,701,383,181	$298,477,680	$2,372,006,395	86.40%	$188,340,354	6.86%	$102,846,587	3.75%
Moda Health	$641,437,857	$299,271,180	$157,742,251	$609,532,375	95.03%	$42,776,759	6.67%	$39,392,541	6.14%
Molina Healthcare	$16,208,000,000	$13,905,000,000	$0	$13,905,000,000	85.79%	$1,296,000,000	8.00%	$737,000,000	4.55%
MVP Health Care	$2,667,420,036	$1,586,107,860	$392,198,968	$2,437,681,294	91.39%	$172,101,778	6.45%	$11,004,648	0.41%
Premera Blue Cross	$3,959,512,228	$2,469,164,382	$419,445,539	$3,407,935,208	86.07%	$423,705,911	10.70%	$101,932,884	2.57%
Priority Health	$4,104,660,400	$2,744,166,038	$472,158,466	$3,543,080,643	86.32%	$360,894,997	8.79%	$188,044,728	4.58%
Regence Group, The	$5,388,277,889	$2,726,174,704	$728,009,640	$4,614,697,577	85.64%	$437,655,744	8.12%	$182,206,001	3.38%
SelectHealth	$3,335,442,653	$1,857,026,283	$461,229,333	$2,880,106,874	86.35%	$204,420,991	6.13%	$197,493,874	5.92%
Triple-S Salud Inc.	$1,581,512,659	$832,131,465	$467,576,257	$1,403,499,732	88.74%	$178,396,246	11.28%	($15,804,939)	-1.00%
Tufts Health Plan	$5,244,399,354	$3,661,338,719	$685,163,883	$4,568,331,902	87.11%	$451,537,525	8.61%	$104,774,528	2.00%
UnitedHealthcare	$193,842,000,000	$156,440,000,000	$0	$156,440,000,000	80.70%	$35,193,000,000	18.16%	$10,326,000,000	5.33%
UPMC Health Plan	$6,485,325,942	$2,536,294,280	$881,082,588	$6,043,720,793	93.19%	$591,612,345	9.12%	$114,376,537	1.76%
Wellmark, Inc.	$3,829,090,409	$2,123,170,075	$458,502,073	$3,167,072,655	82.71%	$335,274,215	8.76%	$261,451,289	6.83%

NOTES: As Centene Corp. completed its acquisition of WellCare Health Plans, Inc. in January 2020, WellCare's 2019 fourth quarter financial data is not available. NA= not available. Medical Loss Ratio=Medical Costs/Premium Revenue. Net Margin=Net Income/Premium Revenue. Administrative Cost Ratio=Admin Costs/Premium Revenue

SOURCE/METHODOLOGY: Prepared by AIS researchers based on selected data points from annual and quarterly financial statements filed with the U.S. Securities and Exchange Commission and relevant state insurance departments. Health plans have been selected based on medical risk enrollment as of beginning of 2017, per AIS's Directory of Health Plans. The data set represents companies identified as Health Insurance, HMO and Hospital, Medical and Dental Service or Indemnity (HDMI) companies. Data are not available for companies identified as life and health, disability, annuity or other insurance companies. Data may represent dental, vision and other lines of business in addition to medical benefits. Some companies are consolidated, representing two or more subsidiaries with premium revenue. Some cost breakdowns may be unavailable. Costs may be defined differently by different sources; administrative costs may or may not include cost of sales. Medical costs include hospital/medical and pharmacy costs, prior to reinsurance recoveries. The publisher does not warrant that the information contained herein is complete or accurate.

News Briefs

✦ ***Molina Healthcare, Inc. said on April 30 that it plans to buy Magellan Health, Inc.'s managed care organization, Magellan Complete Care (MCC), for about $820 million.*** MCC served approximately 155,000 members across six states as of Dec. 31, 2019, and it reported full-year 2019 revenues greater than $2.7 billion. "Acquiring MCC expands our geographic footprint in our core businesses of managed Medicaid, dual eligibles, and long-term services and supports," said Joe Zubretsky, president and CEO of Molina. "We believe it will allow us to scale our enterprise-wide platforms and benefit from both operating and fixed cost leverage." By adding MCC to its portfolio, Molina expects to serve more than 3.6 million members in government-sponsored health care programs in 18 states and will have 2020 pro-forma projected revenues of over $20 billion. The deal, which has not yet been approved by regulators, is expected to close in the first quarter of 2021. Read more at https://bwnews.pr/2xsW71q.

✦ ***UnitedHealth Group's Optum division is in advanced talks to acquire the tele-behavioral health provider AbleTo, CNBC reported, citing people familiar with the potential deal.*** Optum's venture arm previously made a "significant" strategic investment in AbleTo — a 12-year-old company based in New York — and the company has also raised money from investors including Bain Capital Ventures and Aetna (now owned by CVS Health Corp.). In addition, AbleTo CEO Trip Hofer was a senior executive at Optum from 2006 to 2012. Read the CNBC article at https://cnb.cx/2z0oWCU.

✦ ***Florida Blue on April 24 unveiled a new affiliated health maintenance organization called Truli for Health.*** The new HMO product, which will be marketed toward small and medium-sized employers, will be initially rolled out in central Florida and select south Florida counties on July 1. The goal is to "expand health care coverage options for local businesses through partnerships with trusted community healthcare providers," according to Florida Blue. Read more at https://prn.to/2SicuVN.

✦ ***The chief medical officers of America's Health Insurance Plans member plans released a "set of clinical principles to promote continued safe, effective, and evidence-based care for Americans in the wake of the COVID-19 crisis."*** The principles include expanding access to alternative sites for care and diagnostic testing; promoting use of virtual care and telemedicine; supporting providers by raising awareness about clinical practices and policy; working with the government and other stakeholders to share and aggregate data on disease progression; educating members and supporting awareness of the public health crisis; and adapting medical management tools to support patients and health care workers. Visit https://bit.ly/3c3HNM1.

✦ ***The dramatic drop in health care utilization due to COVID-19 includes a decrease in acute care treatment, not just elective procedures, according to an internal study of Cigna Corp. claims data.*** The study examined U.S. commercial claims for inpatient treatment and authorization requests between February 2020 (pre-pandemic) and March 2020, discovering that rates of hospitalization decreased during that period. "While variations are expected month to month, the results and the consistency of the decreased hospitalizations were striking," Saif Rathore, M.D., Cigna's head of data and analytics innovation, said in a press release. "We believe these data call for efforts to ensure patients continue to seek and access critical clinical care during the current COVID-19 pandemic." Read more at https://bit.ly/35kb56b.

✦ ***Most insurance executives expect premiums to remain stable in 2021 despite waiving or delaying cost sharing for pandemic care, according to a survey conducted by online, private health insurance marketplace eHealth.*** According to the survey, which took place between March 30 and April 2, 97% of respondents' firms waived out-of-pocket costs for coronavirus testing, and 60% have allowed members to delay paying premiums if needed. Eighty-three percent of respondents did not expect to raise 2021 rates specifically "in response to the crisis," while the remaining 17% expected rates to go up no more than 5%. Meanwhile, 80% of respondents said they expect claims for elective treatment to surge when the pandemic ends, while 73% expect that surge in six to 12 months. View a slide deck with the results of the survey at https://bit.ly/2Smzpz0.