Strategic Business, Financial and Regulatory Analysis of the Health Insurance Industry

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Winners, Losers Remain Unclear With Surprise Billing Fix

After years of failed attempts, Congress has finally come to an agreement on a measure to end the practice of surprise medical billing — leaving experts debating whether the new policy can slow the growing cost of health care and the inflation of premiums. The legislation is part of the Dec. 21 Consolidated Appropriations Act, a coronavirus economic relief bill that was passed by Congress but at press time faced an uncertain future after President Donald Trump on Dec. 23 condemned the bill's $600 direct payments to Americans as too low.

Surprise billing, also known as balance billing, is the practice of charging patients for out-of-network procedures that insurers refuse to pay for in whole or in part. Often, patients incur these balance bills without their knowledge: Some patients are incapacitated when treated by an out-of-network specialist like an anesthesiologist and cannot consent to the procedure they receive. The new legislation would ban providers from sending such a bill to patients, and would instead require providers to negotiate reimbursement with the patient's insurer or submit the dispute to a binding arbitration process. The measure would not apply retroactively.

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Payers See Value in Job Training for Medicaid Members

The University of Pittsburgh Medical Center is the largest employer in the Pittsburgh area, with hundreds of job openings on any given day. At the same time, the integrated network's UPMC Health Plan covers nearly one in five Medicaid beneficiaries in the state of Pennsylvania.

So when the health plan launched its Pathways to Work program this July, it made sense for Medicaid members to be a focal point of the program's workforce development efforts.

"Our mission is to provide job opportunities, training, and education, both to members and the community," says Dan LaValle, the director of social impact for UPMC Health Plan, which has roughly 1.3 million covered lives in Pennsylvania.

The program aims to help members find jobs with the health plan and health system — about 800 members have been hired in the last three-and-a-half years — but also with employers throughout the area. "The pandemic was a stark reminder that we can make a huge difference here," LaValle tells AIS Health.

UPMC Health Plan is one of a growing number of insurers offering new or expanded job training and placement programs to Medicaid members. For example, CareSource, which has about 1.4 million Medicaid members in Georgia, Indiana and Ohio, offers workforce development services as part of its Life Services program. This program connects members with a life coach to help them secure employment, including obtaining a high-school diploma or GED if necessary.

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Other services include online professional development and skill-building sessions, sample job applications, and interview prep. Support is also available for up to two years after a member has started a job.

In addition, national insurer Anthem, Inc., which has more than 5.5 million Medicaid covered lives across 17 states, has recently partnered with Aunt Bertha, a public benefit corporation that helps connect people to social services programs such as food assistance and job training. Care teams and providers can help members search for services in their area and view contact information, hours of operation and next steps for receiving assistance.

For Anthem, the goal is to emphasize whole-person health and quality of life, according to Leigh Davison, staff vice president of Medicaid strategy and initiatives.

"Perceived job insecurity, downsizing or workplace closure, and underemployment can all have negative implications for physical and mental health," Davison explains.

Expansion of these initiatives comes at a time when Medicaid work requirements are making headlines. On Dec. 4, the U.S. Supreme Court said it would hear arguments on the legality of work requirements. Under the Trump administration, CMS has encouraged states to apply for waivers that would require certain Medicaid beneficiaries to prove that they are working, looking for a job, or enrolled in a job training program in order to retain Medicaid coverage. Experts say that the Biden administration will likely try to reverse those waivers *(HPW 11/13/20, p. 1)*.

According to the Kaiser Family Foundation, Medicaid work requirement waivers have been approved in 12 states. However, lower courts have struck down work requirements in Arkansas, Kentucky, Michigan and New Hampshire, and some other states with approved waivers have not yet implemented their programs.

According to a 2019 analysis from the Kaiser Family Foundation, 63% of adult Medicaid beneficiaries in the U.S. are working, and only 7% are not working due to an inability to find work. The remainder of beneficiaries are not working due to illness or disability, school attendance or their role as a caregiver.

"It's such a [misconception] that people on Medicaid don't want to work," LaValle says.

UPMC Health Plan's program is not tied to a Medicaid work requirement waiver. While Pennsylvania's Republican-controlled legislature has repeatedly proposed bills that would direct the state to apply for such a waiver, Democratic Gov. Tom Wolf has vetoed these bills and indicated that he will not support similar legislation in the future.

Job Placement Yields Results

Instead of work requirements, in January 2020 Pennsylvania launched a program called Medicaid Work Supports, which connects new enrollees in Medicaid plans with employment resources as well as assistance with obtaining a diploma or GED.

"When we get new Medicaid members, they tell us if they're interested in work support, and we try to help them wherever they are at," LaValle says. Beyond simply referring members to a job listing website, the goal of the program is to help new members find work regardless of their level of education or previous type of employment. In one recent example, new members who had recently worked in retail roles were hired for customer service roles at UPMC Health Plan, he notes.

"We're helping people navigate the employment space. What we heard from the community is that people just needed someone to talk to, to bring hope and compassion and action," LaValle says. "We spend a little more time with people. We have multiple conver-

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sations and help people find their way. It's as simple as communicating with them and building that trust, to help them see where their life experiences have led them."

Industry experts suggest that insurers' job training programs offer a broader benefit than just meeting the needs of Medicaid work requirement waivers or filling job vacancies.

"Health plans look at stable employment as just one of the many social determinants of health that they've been trying to address. Like access to safe, affordable housing and food security, having a steady job leads to better health outcomes," says Jerry Vitti, founder and CEO of Healthcare Financial Inc., a firm that connects low-income, elderly and disabled populations with public benefit programs. "Providing job training resources helps plans fulfill their primary goal of keeping their members healthy. That in turn lowers costs and yields a positive ROI for the plan."

Preventive Indicators Improve

CareSource said in 2018 that it observed an 18% drop in emergency department use and a 15% decrease in outpatient expenditures among members in the first months of participation in the Job Connect program, compared to the six months prior to joining the program. In addition, CareSource has seen a 22% increase in prescription drug spending, which the insurer views as a driver for preventing chronic conditions down the road.

Abner Mason, founder and CEO of ConsejoSano, agrees with this assessment. ConsejoSano provides health plans, providers and employers with engagement tools designed to meet the needs of non-English speakers and multicultural populations.

"The further upstream you go with interventions, the more effective they are, and the more savings we see over time," Mason tells AIS Health. "Unemployment is a social determinants of health barrier, and it directly impacts, in dollars and cents, when people access health care. If they don't have cash on hand for a copay or for a prescription, they hold off, and little problems then turn into big, expensive ones."

For Anthem, it's important to be able to link newly working Medicaid members with resources above and beyond job training to help remove barriers to employment. These could include transportation, child care and housing, Davison says.

> **"Health plans look at stable employment as just one of the many social determinants of health that they've been trying to address.**

"A loss of any one of those supports could potentially derail completion of training or cause an individual to miss a job opportunity. With steady employment, many social determinants of health supports could be lessened and even resolved," she says.

The job training programs also help health plans connect with their communities. CareSource's Job Connect program got its start when the insurer hosted a hiring event on behalf of a glass manufacturing company that wanted to hire 1,000 workers for its new plant in Dayton, Ohio. Anthem has employed 16 college students in its Atlanta-based IT apprenticeship program, Davison says. These students work and obtain a degree in an IT field over the course of five years. The program is part of a larger effort to work with community organizations to train individuals in soft skills and help them obtain professional certifications in high-demand fields such as IT or health care, she adds. UPMC and UPMC Health Plan have recently launched a program called Freedom House 2.0, a grant-funded initiative to recruit high-risk youth and individuals replaced by COVID-19 — including the health plan's Medicaid members — for emergency medical service (EMS) training and certification. This program takes its name from the initial Freedom House, an ambulance service founded in 1967 by UPMC anesthesiologist Peter Safar, M.D.

Safar drew recruits from the low-income and predominantly Black Pittsburgh neighborhood known as the Hill District and trained them in IV and medication administration. The first program helped set a national standard for paramedics training, according to Dan Swayze, vice president of community services for UPMC Health Plan. Prior to its inception, city police or funeral homes typically provided ambulance services, which led to poor outcomes. The hope is that Freedom House 2.0 will do similar work by pioneering the role of the "community paramedic" who can assess individuals for mental health needs or other social determinants of health when responding to 911 calls.

"We want not only give students and participants a new career trajectory but to also transform the whole EMS industry," Swayze tells AIS Health.

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by Brian Eastwood

Insurers' Diversity Policies Must Start at Top, Executives Say

Internal equity and diversity programs could be a powerful business strategy for plans that serve under-resourced populations, two experts say.

But to make these programs truly effective, organizations must start at the top and embed equity and diversity principles in everything they do, moving beyond a mere "box-checking" mentality, said Sachin Jain, M.D., president and CEO of SCAN Group and SCAN Health Plan, based in Long Beach, Calif.

"I would say one of the biggest obstacles that we have is our false sense of security that we're actually doing something about this problem," Jain said during a Dec. 8 virtual panel at America's Health Insurance Plans' Consumer Experience & Digital Health Forum 2020. "Our industry is awash with pilot projects, initiatives, huge press releases and buzzwords around projects that we're doing around social determinants of health and social and health inequity."

Such initiatives, plus the act of hiring a chief health equity officer, make insurers believe they've solved the problem, Jain said, adding, "unfortunately, I will say that diversity and health equity have become a box-checking exercise in our industry." The only way to make real progress is to start from the top, where the leadership often "can't even imagine the extent to which we have health care disparities," he said.

"We have to lead with new leadership. We have to evolve our cultural dialogue around these topics," Jain said. "But we also have to recognize that you can't be a good business in 2020 and not actually be excellent at serving diverse populations. I see that, from the seat that I'm in, as opportunity."

When Jain came on board in June as CEO of SCAN Health Plan, one of the largest not-for-profit Medicare Advantage plans, he directed the organization to look at data on racial equity and diversity, including both health data from members and data from within SCAN itself. "Our African-American employees trust [company] leadership less than our non-African-American employees by about 0.5 on a five-point scale. That's a big problem. It's something I've got to solve," he said. "On Medicare Advantage star measures, our African-American patients do way worse on pharmacy measures than our white patients. That's an opportunity for us to get better."

SCAN Looks 'Across the Organization'

SCAN's leaders recognized that they were not "thinking diversely across all of our processes across the organization," Jain said. To begin remedying that, the health plan on Dec. 9 announced that it hired three new executives and promoted another to support diversity. Timshel Tarbet, SCAN's new vice president of business excellence and diversity strategy, will lead the effort.

"Her job will be to look at literally everything we do as an organization — member services, sales, [and] clinical management — and look at the ways in which we can apply a lens of health, equity and diversity to ensure that we're using diversity as a growth strategy and as a success strategy, as opposed to a box-checking exercise," Jain said.

MCO Stock Performance, November 2020

	Closing Stock Price on 11/30/2020	November Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2020 EPS*
COMMERCIAL				
Cigna Corp.	$209.14	17.9%	2.0%	$18.59
UnitedHealth Group	$336.34	7.6%	15.0%	$16.76
Anthem, Inc.	$311.52	10.7%	3.5%	$22.41
Commercial Mean		**12.1%**	**6.9%**	
MEDICARE				
Humana Inc.	$400.52	(3.5%)	10.3%	$18.63
Medicare Mean		**(3.5%)**	**10.3%**	
MEDICAID				
Centene Corp.	$61.65	0.5%	(0.4%)	$5.00
Molina Healthcare, Inc.	$204.13	10.4%	53.1%	$12.60
Medicaid Mean		**5.4%**	**26.3%**	
Industry Mean		**7.3%**	**13.9%**	

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

SOURCE: Bank of America Merrill Lynch.

Tarbet will report directly to him, Jain said. That's important, he noted, since traditionally this type of position is placed in human resources. She will be "empowered to work across the whole organization to drive change," he added. "That's the kind of thing we're doing that I think is going to begin to make a difference. The job is to literally transform all of our business processes, to make sure that we are culturally competent and culturally aware and business-forward, as it relates to serving all of these diverse populations."

SCAN also has ramped up its measurement work, he said. "We're starting to take a hard look at how we perform across diverse populations," using pharmacy data to see how the plan is doing from a Medicare stars perspective, Jain said. "Demographically, southern California is very diverse. But I would say we haven't won our share of that diversity. When we look at the population that we serve, it doesn't always reflect the population of people who live in southern California, because we haven't done as good a job as we should do reaching out to the Chinese American community, the Vietnamese American community, the Filipino community, all of which have very significant populations in our geographies."

Trade Groups Grapple With Diversity

Jain said he's starting to see smaller competitors for that business, which is putting pressure on SCAN to win and serve a diverse membership. In addition, he said that he expects large employers to begin to ask more questions surrounding health equity and to factor the answers into their decisions on insurer choice and plan design.

Even health care trade groups are grappling with these issues. Aletha Maybank, M.D., chief health equity officer and group vice president at the American Medical Association (AMA) Center for Health Equity, told meeting attendees that the AMA is performing many of the same tasks as SCAN Health Plan: "looking at our performance metrics, our policies, our culture of the organization to make sure that we're embedding equity in this way," Maybank said. "That's the theory of change. You can't do equity work on the outside with partners, people or patients unless you're really looking internally into your institutional ways that actually prevent you from advancing equity."

The AMA approved a policy two years ago to form an organizational unit — the Center for Health Equity — and to add a chief health equity officer, whose role is to embed health equity across the entire enterprise.

Educating Teams is Critical for Equity

Most health care leaders understand that they need to promote diversity and equity among their leadership and workforce, Maybank said. But to make significant progress, "every single sector within our institution has to be looked at. If they don't even understand what the word 'equity' means, we're in trouble."

To fix the problem, Maybank said, organizations first need to educate teams "so that folks actually get this." Then, those teams can change policies, practices, culture and research, she said.

If the organization's top leadership is not on board with this approach, then "this work does not move forward in meaningful ways," Maybank said. The AMA's leaders are on board, she said, and the organization already has required that all vice presidents and above take two-day racial equity training, while a new diversity and equity curriculum is being disseminated through the organization.

The pandemic also has exacerbated some equity issues, Jain said. For example, telehealth has grown exponentially since March, but some people — particularly those in underserved populations — don't have access to the technology. To combat this problem, SCAN created a technology help desk as a new benefit for 2021, and actually has provided devices to people who need them to access health care, he said. "I think it's up to this industry to provide leadership around this in a year of record profits," Jain added.

Fixes Are 'Just The Right Thing to Do'

Still, the digital equity and diversity problem is broader than just health care, Maybank said, noting that the lack of broadband in underserved communities impacts care. In addition, physicians and entrepreneurs of color often have difficulty accessing start-up funding for projects, she said.

Jain said he's going to revisit an idea SCAN had several years ago that would involve negotiating lower broadband costs for members and making that a part of the MA plan benefits. This is the type of benefit other plans should consider, in part to address inequities, he said.

"Our industry has a history of looking at benefits purely from the perspective of 'Will it sell me more health plans?' or 'Will it reduce medical costs?'" Jain explains. "And the truth is, those are good reasons to introduce benefits, but they're not the only reasons to offer benefits. Sometimes, the reason to offer a benefit is because it's just the right thing to do."

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by Jane Anderson

Bill Will Ban Most Surprise Billing

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Providers will have 30 days from the day of the procedure to negotiate a compromise reimbursement amount with payers. If the parties can't agree, they must submit their preferred reimbursement amounts to an HHS-approved arbitrator, who will pick one of the two amounts based on factors such as the procedure's median in-network price and prevailing regional cost. Arbitration is binding and final — it cannot be appealed — and the loser is required to pay for the administrative costs of the arbitration. A provider will have to wait 150 days after the decision to initiate arbitration for subsequent procedures with the carrier in question. The legislation addresses surprise billing from hospitals, outpatient facilities and air ambulances — but not ground ambulances.

Measure Is 'Closer to the Ideal'

Loren Adler, associate director of the USC-Brookings Schaeffer Initiative for Health Policy, praised the legislation as "closer to the ideal, consumer-friendly solution" than previous attempts to address the issue. A serious attempt by Congress to tackle surprise billing stalled in December 2019, and other measures languished in committee for most of this year *(HPW 2/17/20, p. 1)*.

"It's very likely that this bill reduces premiums," Adler tells AIS Health. Adler has contributed to research that found surprise billing increases premiums for the entire health care system. "That's the headline of the bill. We're pretty confident in the fact that surprise billing has been inflating premiums, and this should do something to reduce that."

Adler is confident the arbitration criteria outlined in the bill will remove some cost from the system, singling out the bill's requirement that arbitrators consider the median in-network rate for a given procedure in their decision.

Insurance stakeholders are displeased that surprise bills will be resolved through arbitration. Instead of arbitration, America's Health Insurance Plans (AHIP) had lobbied for out-of-network reimbursement to be tied to a benchmark rate. In a Dec. 12 statement released before the bill's final language was made public, AHIP CEO Matt Eyles emphasized the group's support for a solution based on "fair, market-based prices based on locally negotiated rates." After the bill passed, Eyles sounded a sour note.

Insurers Opposed Arbitration Mechanism

"While we appreciate Congress' work to protect patients from surprise medical bills, we remain deeply concerned that hardworking American families and businesses will face increased costs and higher premiums as private-equity firms exploit arbitration processes," Eyles wrote in a Dec. 21 statement. "We have already seen this play out in Texas and New York, which have both experienced first-hand the harms of arbitration on consumers."

Adler thinks that insurers' objections to arbitration are overblown, and he argues carriers will gain leverage in balance bill negotiations because of the legislation.

"It seems pretty easy for an insurer or a [plan sponsor] company to call a provider's bluff," Adler says, citing the long waiting period, which he thinks will prevent providers from abusing the arbitration system. He predicts cash flow considerations will force providers to accept insurers' rates far more often than they go to arbitration.

Insurers, Adler suggests, can take a strong position: "I [the insurer] see that the arbitrator is awarding you the old, out-of-network rate, but fine, I'm going to keep paying you the median, because that's what I think is fair. And sure, you'll win a case every 90 days, but now you're [the provider] getting [a net] 115% of the median [rates]? I think it gives insurers a pretty strong lever, and it's something that did not exist in the other bills."

Rules Should Prevent Abuse of Process

Other experts aren't so sure.

"It definitely tilts the field in the direction of the provider," Jack Hoadley, Ph.D., research professor emeritus at Georgetown University's Health Policy Institute, tells AIS Health. However, he does agree with Adler's conclusion about abuse and systemic cost.

"There are a number of important guardrails on the arbitration process that would prevent it from being misused, and help to prevent it from becoming inflationary," Hoadley explains. "Some of that has to do with some of the factors that are to be considered as part of the arbitration decision. The arbitrator's not supposed to look at the bill charged — one of the things we've seen in some of the states that have [implemented surprise billing regulation] is that the bill charged, or 80% of the bill charged, has become something of a benchmark for arbitrators in making these decisions. This legislation says that the arbitrator should not look at the bill charged. They're suggested to look at the in-network rate [instead]."

Hoadley also thinks that the cost of arbitration will be a deterrent against abuse.

"The loser in the arbitration determination has to pay the administrative cost for that arbitration," Hoadley says. "So that's kind of an incentive to make sure that you think you have a

good case before you go to arbitration, because if you lose, you'll get the lower payment amount — and you'll have to pay that administrative charge on top of it."

Dan Mendelson, founder of Avalere Health, is more skeptical than Adler and Hoadley about the bill's potential to reduce costs and slow premium inflation.

"There is no question that whenever you force more cost into the system, it's going to be reflected in consumer cost," Mendelson explains. "So there will be a premium effect. Will people actually be able to differentiate it from the typical rise in costs? No....I do expect that it will have an effect, just from an economics standpoint."

Mendelson points out that many important questions will be answered by the Biden administration. Adler also emphasized that point, citing HHS's ability to decertify arbitrators who favor one side or another.

"How is it done, what are the ground rules? A lot of that is going to be worked out through regulation that is going to be promulgated by the Biden administration," Mendelson explains. "They will determine how it will actually affect providers and plans. And they're going to need that discretion to make the program work — it's going to be administratively burdensome and complicated to set up this kind of an arbitration system, and expensive, too."

Mendelson adds that Congress will have to take up the ground ambulance balance billing matter separately. All that said, he thinks Congress has done admirable work.

"It puts the problem squarely back between the providers and the insurers," Mendelson says. "From a consumer standpoint, it's really positive."

Read Adler's research on surprise billing's systemic cost at http://brook.gs/2KmSv7H and view the appropriations act at https://bit.ly/34Ff2U4. Contact Adler at ladler@brookings.edu, Hoadley at jfh7@georgetown.edu and Mendelson via Liz Moore at lmoore@avalere.com. ✧

by Peter Johnson

News Briefs

✦ ***On Dec. 22, Congress voted to repeal health insurers' exemption from federal antitrust laws by amending the McCarran-Ferguson Act, which expressly delegated health insurance competition questions to states.*** The bill would allow the Federal Trade Commission and Dept. of Justice to take action under federal antitrust law if health insurance companies engage in anti-competitive practices. The bill does not prevent states from enforcing their own rules. However, a Dec. 2 letter signed by four state insurance commissioners, each of whom were appointed by Republican governors, announced the opposition of the National Association of Insurance Commissioners (NAIC) to the bill. The commissioners argued that "existing state consumer protection, antitrust, and unfair trade practice laws provide the necessary tools needed to help stop anti-competitive conduct. Adding a layer of federal review would only lead to increased costs, confusion, and possible conflicts in federal and state courts." Matt Eyles, CEO of America's Health Insurance Plans (AHIP), condemned the bill in a Dec. 22 statement, arguing it will "[add] administrative red tape and reduc[e] market competition while making health coverage less affordable for hardworking Americans.… It will unnecessarily add layers of bureaucracy, destabilize markets, create conflicting federal and state oversight requirements, and lead to costly litigation." Read the bill at http://bit.ly/3nPmyDl and the NAIC letter at https://bit.ly/2WDRtqg.

✦ ***Lyft Inc. will offer 60 million rides to COVID-19 vaccination sites for low-income, uninsured and at-risk people who might be unable to access the vaccine otherwise.*** The program will be sponsored by partners including Anthem, Inc., Centene Corp., Epic Systems Corp., One Medical Group Inc., JPMorgan Chase Co. and United Way. "Access to reliable transportation represents a major barrier to care for millions of Americans across the country," said Megan Callahan, VP of Lyft Healthcare. "The COVID-19 pandemic has exacerbated this problem, creating a huge challenge in making sure vulnerable populations have access to the vaccine — especially for seniors living alone, low income workers, and parents with young children." Gail K. Boudreaux, President and CEO of Anthem added that "with the highly anticipated vaccine now rolling out across the country, we are pleased to be joining Lyft and other leading partners to ensure our nation's most vulnerable consumers will have the opportunity to receive the vaccine." Read more at http://bwnews.pr/3rp4nXh.

By the Numbers: The National Health Insurance Market in 2020

by Jinghong Chen

The year 2020 has been filled with unpredictability amid all the changes ushered in by the COVID-19 pandemic. Because of the pandemic-driven economic crisis and ballooning unemployment, member enrollment has seen significant shifts from commercial health coverage toward managed Medicaid plans, according to AIS's Directory of Health Plans. Though insurers are required to cover coronavirus testing and many chose to waive out-of-pocket costs for coronavirus treatment, their gross margins soared compared to 2019 as a result of significant drops in elective and routine care utilization.

Top 5 Insurers in the Commercial Risk Market

Insurer	Enrollment in 2020	Market Share	% Change from 2019
UnitedHealthcare	7,950,145	11.4%	-7.6%
Kaiser Foundation Health Plan	7,063,781	10.1%	1.6%
Anthem, Inc.	6,074,000	8.7%	-2.5%
Aetna, part of CVS Health Corp.	3,268,000	4.7%	-8.2%
Centene Corp.	2,876,152	4.1%	11.7%

Top 5 Insurers in the Medicare Advantage Market

Insurer	Enrollment in 2020	Market Share	% Change from 2019
UnitedHealthcare	6,495,249	25.8%	8.8%
Humana Inc.	4,527,982	18.0%	11.5%
Aetna, part of CVS Health Corp.	2,661,642	10.6%	14.7%
Anthem, Inc.	1,398,589	5.5%	17.9%
Kaiser Foundation Health Plan	1,257,753	5.0%	3.5%

Top 5 Insurers in the Medicaid HMO Market

Insurer	Enrollment in 2020	Market Share	% Change from 2019
Centene Corp.	8,442,397	14.4%	12.3%
Anthem, Inc.	6,380,234	10.9%	17.8%
UnitedHealthcare	5,193,802	8.9%	11.0%
WellCare Health Plans, Inc.	4,133,439	7.1%	9.1%
Molina Healthcare, Inc.	2,898,025	5.0%	6.7%

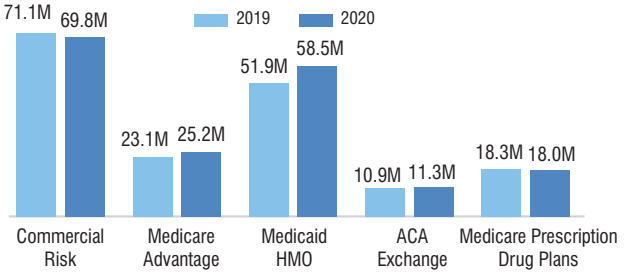
Top 5 Insurers in the Affordable Care Act Exchange Market

Insurer	Enrollment in 2020	Market Share	% Change from 2019
Centene Corp.	2,200,062	19.4%	18.3%
Florida Blue	1,090,000	9.6%	5.8%
Kaiser Foundation Health Plan	535,000	4.7%	7.0%
Anthem, Inc.	497,000	4.4%	-16.0%
BCBS of North Carolina	415,000	3.7%	-7.7%

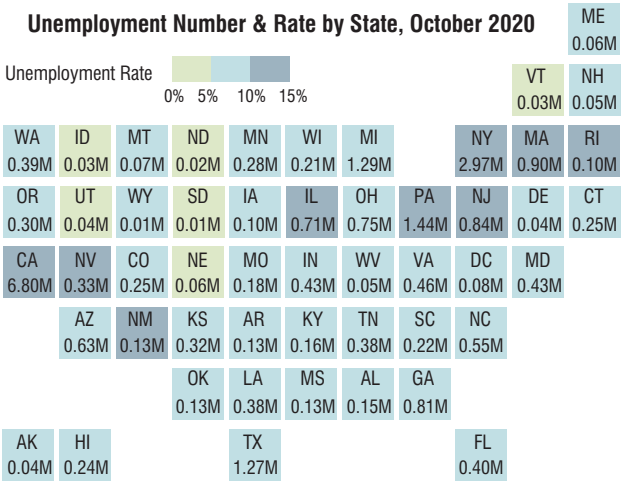
NOTES: Per AIS's research methodology, Medicare Advantage membership include lives enrolled in Medicare Advantage plans, dual-eligible special needs plans and CMS's Financial Alignment Initiative demonstration plans for Medicare-Medicaid dual eligibles.

SOURCES: AIS's Directory of Health Plans, as of December 2020 and 2019. Managed Markets Insight & Technology, LLC, as of October 2020. "Health Insurer Financial Performance Through September 2020," Kaiser Family Foundation. Visit https://bit.ly/37GYz3K.

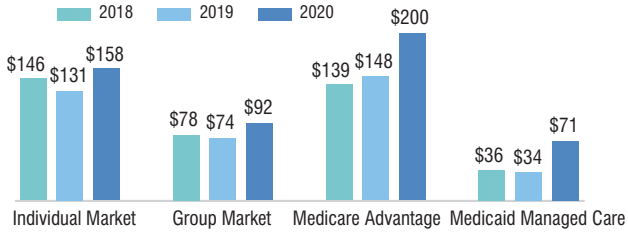
Enrollment by Line of Business



Unemployment Number & Rate by State, October 2020



Average Gross Margins Per Member Per Month Through September



Average Medical Loss Ratios Through September