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Rebate Rule Is Delayed, Likely to Be Repealed by Congress

The Biden administration will suspend implementation until 2023 of the so-called "rebate rule," a Trump administration regulation that would have revamped the Medicare prescription drug rebate system. D.C. insiders expect Congress to eliminate the rule before then for budgetary reasons, but say that drug pricing and PBM regulation will be high on the health care agenda after policymakers address the latest issues arising from the COVID-19 pandemic.

The suspension comes in response to a suit against the rule by a PBM trade group, the Pharmaceutical Care Management Association (PCMA), which sought to overturn the rebate rule on the grounds of its rushed implementation. A court order brokered in the U.S. District Court for the District of Columbia stipulates that all provisions of the final rule that were scheduled to take effect on Jan. 1, 2022, are now postponed until Jan.1, 2023, and it directs the parties involved in the lawsuit to issue a joint status report "identifying whether and how this case should proceed by not later than April 1, 2021."

According to attorney Rachel Sachs, an associate law professor at Washington University in St. Louis and an expert on drug price regulation, PCMA's strongest legal position against the rebate rule stems from the rushed process that created it. The Administrative Procedure Act requires a 60-day comment period between the proposal and finalization of a new regulation, and HHS didn't follow the usual process with the rebate rule.

continued on p. 7

With New Order, Biden Alludes to Array of ACA Rule Changes

Late last month, President Joe Biden issued an executive order (EO) that made headlines chiefly because it reopened the federal health insurance exchange and signaled that the end is near for controversial Trump-era Medicaid policies like work requirements. Yet the language in the order also indicates that Biden is directing federal regulators to make a host of revisions to the rules governing the Affordable Care Act (ACA) exchanges, which the Trump administration generally sought to loosen.

In his order, Biden tells federal agency leaders to review all existing regulations, orders, guidance documents and policies to determine if those actions violate the administration's goal to "protect and strengthen Medicaid and the ACA and to make high-quality healthcare accessible and affordable for every American." Per the order, that includes:

- ***Policies or practices that could erode protections for people with preexisting conditions***,
- ***Demonstrations and waivers (and associated policies) that could reduce coverage under or otherwise undermine Medicaid or the ACA***,

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✦ ***Polices or practices that could undermine the ACA marketplace*** or the individual, small-group or large-group health insurance markets,

✦ ***Policies or practices that "present unnecessary barriers"*** to people attempting to access Medicaid or ACA coverage, and

✦ ***Policies or practices that could reduce financial assistance or make health coverage less affordable***, "including for dependents."

"Looking at that EO, the places where my mind went, of course, were the Trump administration's policies on short-term plans and association health plans — I thought that's probably what they were getting at with the bullet on protecting people with preexisting conditions," says Sabrina Corlette, a research professor at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms.

In the summer of 2018, the Trump administration issued two final rules that lifted restrictions on a pair of alternatives to ACA exchange policies: short-term, limited duration (STLD) plans and association health plans (AHPs). Amid concerns from ACA supporters over those rules' potential to destabilize the exchanges, both regulations have faced court challenges — with the STLD rule surviving and the AHP rule awaiting an appeals court decision (though the Biden administration has asked for a delay in that case). Those types of plans also are not governed by the same rules as ACA-compliant plans, leading consumer advocates to argue that they provide inadequate coverage to enrollees.

But Joseph Antos, a health care scholar at the American Enterprise Institute, says he isn't certain that the Biden administration will want to completely reverse the Trump-era changes to STLD plans and AHPs.

"It's hard to say because the politics may not work for Biden," he tells AIS Health. Antos argues that Democratic voters may be turned off by losing access to plans that have become especially popular among people who don't qualify for subsidies to purchase more comprehensive coverage from the exchanges.

"I think what's most likely is not just trying to pull all these [Trump-era policies] back, but rather to start imposing new restrictions or requirements on what the plans can be," Antos says.

"Another move that I think would be smart for the Biden administration would be to give guidance to the insurance commissioners on what their authorities and responsibilities could be as the federal government now interprets it," he adds. "So, in other words, if you're going to do something that might annoy a voter, let the insurance commissioners handle it."

State Flexibilities Could Be Rolled Back

Regarding the second bullet point in Biden's order — which tells agencies to review demonstrations and waiver policies — Corlette suggests that could be referring to not only controversial Medicaid waivers like work requirements or block grants, but also to the Trump administration's moves to expand what states can do with Section 1332 waiver authority under the ACA.

CMS in 2018 issued guidance to states that was intended to "loosen excessive restrictions" imposed by the Obama administration on state innovation waivers, inviting states to test programs such as restructuring ACA subsidies or replacing a centralized exchange with direct enrollment through insurers and brokers *(HPW 10/29/18, p. 1)*.

In the final days of the Trump administration, CMS granted Georgia a waiver that would take advantage of the new direct-enrollment flexibilities, which in short order was met by a lawsuit. Before that court challenge, however, CMS codified the new 1332 flexibilities — and the ability to set up a direct-enrollment program even without a waiver — in the 2022 Notice of Benefit and Payment Parameters

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Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

(NBPP) for ACA exchange plans. The agency finalized some of the more controversial aspects of that rule right before former President Donald Trump left office, meaning the Biden administration must restart the rulemaking process if it wants to reverse those policies.

New Payment Notice Is Likely

Corlette says that a do-over of the NBPP is probably going to be one of CMS's first moves to comply with Biden's new executive order. "They're going to have to do a new payment notice no matter what, [laying out] sort of what the rules of the road are for 2022, and they're going to have to do that really quickly because…carriers have to develop their plans and rates for 2022 pretty early," she points out. "That whole process starts to kick into gear in just a couple of months — and the more certainty the carriers have about policy, the lower their rates, the more participation you get."

Because the NBPP typically includes a large number of provisions, it could be the vehicle that the Biden administration uses to reverse the controversial 1332 guidance, the new direct enrollment flexibilities, and a host of other Trump administration moves that arguably undermined the ACA exchanges, Corlette says. Specifically, she highlights policies that slashed funding for HealthCare.gov marketing and consumer-navigation programs — including reducing health insurers' exchange user fees — and rules that required people to file more paperwork to prove they're eligible for exchange coverage.

Meanwhile, some health policy observers have observed that the EO seems to reference the ACA's so-called "family glitch," as it mentions improving the affordability of coverage or financial assistance, "including for dependents."

The family glitch dates back to the early days of ACA implementation, when regulators were setting rules that defined what would be considered an affordable offer of employer-sponsored coverage — a key task since people with such an offer aren't eligible for ACA subsidies. They determined that the affordability test should be based on the cost of self-only coverage, even for people who need to include a spouse and/or dependents on their plan, and that standard remains in effect.

But that's a problem because "a lot of employers do not subsidize dependent coverage to the same degree as they subsidize self-only coverage," Corlette explains. "So a lot of times what happens is, a plan will look affordable when you're just looking at the self-only premium, but after you add the wife and kids, it well exceeds the threshold," which is 9.86% of total household income. One estimate put the approximate number of people affected by the family glitch at 6 million, she adds.

Fixing the family glitch would "require the Treasury Department to reinterpret its current regulations, which it has the authority to do using notice-and-comment rulemaking procedures," Katie Keith, who is also research professor at Georgetown University's Center on Health Insurance Reforms, wrote in a Jan. 29 blog post about Biden's executive order.

HRA Guidelines Could Be Tightened

For his part, Antos says he thinks the executive order could encourage federal regulators to tighten up the rules surrounding health reimbursement arrangements (HRAs). The Trump administration finalized regulations in mid-2019 that expanded employers' ability to use HRAs to reimburse workers who buy their own health insurance policies *(HPW 7/1/19, p. 1)*.

Antos points out that those new rules "didn't have any particular enforcement mechanism that ensures plans adhere to ACA requirements," so the Biden administration might want to issue guidance to remedy that. "They could basically say, 'Employers, if you're going to do this, here are the rules as we interpret them, and you're going to have to start reporting, you're going to start having greater oversight,'" Antos says.

Read the executive order at https://bit.ly/36HFnlf and Keith's blog post at https://bit.ly/2YHBE2Q. Contact Corlette at sabrina.corlette@georgetown.edu and Antos at jantos@aei.org. ✧

by Leslie Small

Cigna, Humana See COVID Costs Creep Up in Fourth Quarter

Although the COVID-19 pandemic has had a largely positive impact on health insurers' bottom lines — given the sheer magnitude of deferred routine and elective care — two publicly traded payers' recent fourth-quarter earnings results show that they are not immune from the myriad costs associated with the case surge that occurred in the fall and winter of 2020.

Cigna Corp., which reported its fourth-quarter and full-year 2020 financial results on Feb. 4, posted an adjusted earnings per share (EPS) of $3.51, missing the consensus Wall Street estimate of $3.68 because of "higher COVID cost in the quarter," as Citi analyst Ralph Giacobbe put it. Most of that pressure was felt in the company's U.S. Medical segment — which houses its commercial and government-sponsored insurance businesses — as fourth-quarter adjusted

income from operations and adjusted margins both declined year over year due to COVID-19 and the one year-return of the health insurance fee.

"COVID-19 related impacts include the direct costs of COVID-19 testing and treatment, the costs of proactive actions taken to support customers, providers, and employees, and decreased specialty contributions, partially offset by a reduction in non-COVID utilization," stated the insurer's earnings release.

In the second quarter of 2020, Cigna — like its other publicly traded peers — found that the savings associated with depressed health care utilization surpassed the costs tied to the coronavirus, Chief Financial Officer Brian Evanko told investors during the company's Feb. 4 earnings conference call. In the third quarter, those two opposing forces basically offset each other, he said, but as infections rose in the fourth quarter, COVID-related costs started to exceed the benefits of care deferral. Thus, Cigna's medical loss ratio (MLR) of 85.5% for the quarter came in 100 basis points above consensus, helping drive its lower-than-expected EPS.

It wasn't all bad news for the company, however, as analysts noted that Cigna's new Evernorth segment — encompassing its PBM and health services businesses — beat their revenue expectations. Looking ahead to 2021, Cigna tweaked its full-year earnings estimate from a range of $20-21 per share to "at least" $20 per share. That projection factors in approximately $1.25 per share in "net unfavorable impacts of COVID-19," the insurer said in its earnings release. Asked for further detail during the earnings call, Evanko said part of that headwind will come from elevated claims costs and revenue pressure in Cigna's medical segment, while another major contributing factor will be "reduced customer volumes."

Jefferies analysts viewed the firm's 2021 EPS estimate of at least $20 as a positive, reasoning without the $1.25 COVID hit, the full-year outlook "would have been above the $20-21 target [management] has reiterated since 2018." Still, Cigna's stocks slid after the release of its earnings report on Feb. 4.

Cigna CEO David Cordani also pointed out to investors that several factors could reduce the $1.25 COVID headwind, such as uptake of effective vaccines and/or therapies and even potentially pricing adjustments. "Big picture, we think you should view it as transient or removeable," he said of the $1.25 estimate.

Humana Recorded Loss in 4Q

Humana Inc., which reported its earnings on Feb. 3, recorded an adjusted $2.30 per share loss in the fourth quarter of 2020 that it attributed in part to rising COVID-related costs. But analysts were not surprised given prior guidance from the company, and they noted that the loss was actually slightly below their consensus estimate of -$2.37 per share.

And unlike Cigna, which does much of its insurance business in the commercial space, Medicare-focused Humana reported that the decline of non-COVID utilization in the fourth quarter more than offset the heightened COVID-related testing and treatment costs that it experienced. In MA specifically, Humana said non-COVID utilization was approximately 15% below

MCO Stock Performance, January 2021

	Closing Stock Price on 1/29/2021	January Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2021 EPS*
COMMERCIAL				
Cigna Corp.	$217.05	4.3%	4.3%	$20.60
UnitedHealth Group	$333.58	(4.9%)	(4.9%)	$18.20
Anthem, Inc.	$296.98	(7.5%)	(7.5%)	$24.99
Commercial Mean		**(2.7%)**	**(2.7%)**	
MEDICARE				
Humana Inc.	$383.11	(6.6%)	(6.6%)	$21.71
Clover Health	$13.95			($0.34)
Medicare Mean		**(6.6%)**	**(6.6%)**	
MEDICAID				
Centene Corp.	$60.3	0.4%	0.4%	$5.22
Molina Healthcare, Inc.	$213.61	0.4%	0.4%	$13.81
Medicaid Mean		**0.4%**	**0.4%**	
Industry Mean		**(2.3%)**	**(2.3%)**	

*Estimates are based on analysts' consensus estimates for full-year 2021.

SOURCE: Bank of America Merrill Lynch.

normal levels by the end of the quarter — a statistic that reinforces a trend cited by multiple insurers in which seniors are deferring care more than other populations during the pandemic.

Investments Affected Humana Results

Humana said two other major factors that affected its fourth-quarter results included "ongoing crisis relief efforts and strategic investments in the company's integrated care delivery model, both of which were heavily weighted to the final months of 2020," and "increased marketing expenses associated with the Medicare Advantage Annual Election Period." Those marketing investments seem to have paid off so far, as Humana CEO Bruce Broussard said during the company's earnings call that the insurer is expecting 11% to 12% MA membership growth in 2021.

Humana estimated that for full-year 2021, its EPS would be in the range of $21.25 to $21.75, "which falls generally in line with consensus and consistent with prior messaging," Giacobbe advised investors in a research note. Jefferies analysts called Humana's 2021 outlook "reassuring," although they observed that the estimate "assumes some very large puts and takes," such as the insurer's "inability to document/code seniors at normal levels during COVID, resulting in lower risk adjustment revenue."

During the earnings call, Chief Financial Officer Brian Kane noted that so far in January, Humana is seeing COVID and non-COVID utilization trends that are similar to what it saw in the fourth quarter of 2020.

Read Cigna's earnings release at https://bit.ly/39KGWRr and Humana's at https://bit.ly/3rkONLw. ✧

by Leslie Small

Experts Call on Congress To Boost Medicaid Funding

Democratic majorities in Congress and the Biden administration can move quickly to bolster Medicaid and expand enrollment in the safety net program, according to a Feb. 3 expert panel convened by the Brookings Institution. The panelists, which included policy experts, state health officials, and former CMS Deputy Administrator Vikki Wachino, observed that Medicaid can play a critical role in blunting the impact of the COVID-19 pandemic on communities of color and preserving states' finances.

Pandemic Puts Spotlight on Medicaid

Medicaid's safety-net role is more important than ever during the COVID-19 crisis. The pandemic's economic devastation has caused sudden, unprecedented growth in Medicaid enrollment — up 8.6% to a total of 77.3 million nationally between February 2020 and September 2020, according to a Jan. 21 report by the Kaiser Family Foundation — as well as losses in commercial insurance coverage.

Moreover, Medicaid members are more likely to be employed in essential industries like grocery, retail and logistics — and many laid-off hospitality workers are eligible for Medicaid even when they are working. In addition, people of color, who have suffered more death, illness and economic harm from the pandemic than U.S. residents as a whole *(HPW 10/16/20, p. 1)*, generally are disproportionately more likely to be enrolled on Medicaid.

Meanwhile, the Trump administration's signature Medicaid policies — such as work requirements — were widely criticized for making the program harder to access. By contrast, the Biden administration has set out to reverse course and emphasize putting as many people on the rolls as possible *(HPW 1/31/21/ p. 1)*.

Valerie Nurr'araaluk Davidson, president of Alaska Pacific University, who previously served as lieutenant governor of Alaska and head of the state's health department, observed that even as the Medicaid program is central to addressing the public health crisis, it is something of a crisis itself.

> **"With regard to stabilizing Medicaid, a lot of it is undoing what has happened recently.**

"We need to…remove barriers to coverage beyond the public health emergency, because, quite frankly, if we're able to do it during a public health emergency, we should be able to do it during a regular course of business," Davidson said, ticking off a list of Trump-era policies that depressed enrollment, including block grants and constraints on states' abilities to retroactively enroll members. "With regard to stabilizing Medicaid, a lot of it is undoing what has happened recently."

Davidson, who is an enrolled member of the Orutsararmiut Native Council, added that any new Medicaid policies have to account for racial disparities. She emphasized that there are special considerations for tribal and indigenous groups, and she explained that Alaska can be a model for states that wish to coordinate with CMS and the Indian Health Service to improve service for indigenous groups.

Dan Tsai, the head of Massachusetts's Medicaid program, said that expanded federal fiscal support to state Medicaid programs must continue indefinitely, and that Congress needs to plan for the period when the pandemic begins to wind down. The Families

First Coronavirus Response Act raised the federal medical assistance percentage by 6.2% for the extent of the public health emergency, but groups including America's Health Insurance Plans have called for a federal Medicaid funding boost of at least 12%.

"It's no secret [that] any state is going to be facing tremendous pressure from the revenue standpoint at the same time it's facing tremendous need.…I think states are in a range of different places, and the support from the federal government is critical here," Tsai said. "We have realities to solve for from a fiscal standpoint.…The [public health emergency] is extended until 12/31. We're going to budget and plan for that. That level of fiscal sustainability is incredibly important, because you're not budgeting quarter to quarter with several, hundred-million-dollar swings in revenue.…However, there's still a cliff at the end of it.…We can all be optimistic, but there are going to be challenges through the end of the year."

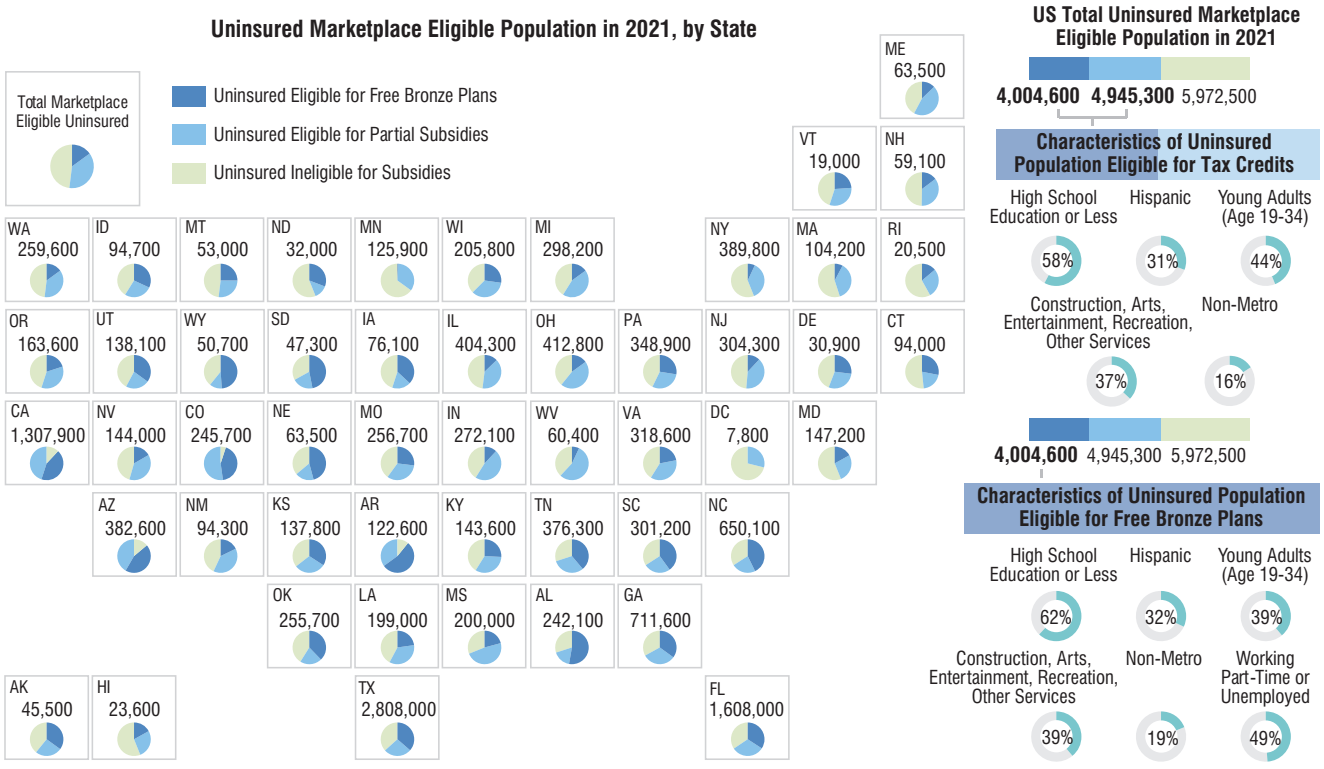
Watch the panel at http://brook.gs/2NXVTqO and read the KFF report at http://bit.ly/39Lg97F. ✧

by Peter Johnson

Nearly 9 Million People Could Benefit From Broadened ACA Enrollment Period

by Jinghong Chen

President Joe Biden on Jan. 28 signed an executive order to reopen the federal health exchange from Feb.15 through May 15. During that special enrollment period, 4 million uninsured people will be eligible for a zero-premium bronze plan on HealthCare.gov, and another 4.9 million could get subsidies to cover part of a health plan, according to a recent analysis by the Kaiser Family Foundation. Compared to the general non-elderly population, these subsidy-eligible uninsured individuals are more likely to be young adults, high-school educated and working in industries such as construction, arts, entertainment and recreation. Approximately 8.3 million people selected or were automatically reenrolled in health plans for 2021 on HealthCare.gov as of the Dec. 15 deadline, according to CMS.



NOTES: The uninsured marketplace-eligible population does not include people with incomes below the federal poverty level (FPL) who fall into the Medicaid coverage gap or those eligible for a Basic Health Plan in Minnesota or New York. The category of people who are ineligible for financial assistance includes people with incomes above 400% of FPL or who live in counties where the benchmark plan costs less than the applicable premium cap for their household income.

SOURCE: "Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach," Kaiser Family Foundation. Visit https://bit.ly/2O4uVxW.

Rebate Rule Gets Put on Ice

continued from p. 1

"The issue is that they initially introduced drafts of them, and then they sat on them for years, or even tried to say that they weren't going forward with them — only to finalize them after the election, in the case of the rebate rule. That's one of the reasons [PCMA] was able to challenge it," explains Sachs. The original rebate rule was pulled in July 2019 amid concerns that it would increase federal spending and Medicare beneficiary premiums, as both the Congressional Budget Office and CMS's Office of the Actuary predicted those outcomes.

Rule Faces Numerous Legal Hurdles

Sachs adds that there are other problems with the rule that make it vulnerable to legal challenges from the PBM industry.

"There were several other substantive allegations, including the scope of the OIG [HHS Office of Inspector General] to review these questions," Sachs explains, noting that the rule was promulgated by the OIG instead of the regular CMS rulemaking process. She adds that, in public comments on the rebate rule, former HHS Secretary Alex Azar claimed that it wouldn't increase federal spending despite the CBO and CMS actuarial reports saying the opposite. Sachs says that contradiction further exposes the regulation to legal risk.

Payers and PBMs both applauded the court order and argued the Biden administration should do away with the rebate rule altogether.

David Root, vice president for public affairs for PBM Prime Therapeutics, which is owned by Blue Cross and Blue Shield affiliates, tells AIS Health via email that "we firmly believe the rule as written will significantly increase beneficiary premiums and government costs and it will not achieve lower prices for the vast majority of consumers. Should the rule move forward without significant changes, we will continue to advocate for a full repeal of the rule."

AHIP Wants Full Withdrawal

Matt Eyles, president and CEO of America's Health Insurance Plans (AHIP), said in a Feb. 1 statement that "we strongly support the stipulation between the Biden Administration and the Pharmaceutical Care Management Association (PCMA) delaying the effective date of the 'rebate rule' until January 2023." The "misguided proposal" will increase premiums for seniors and people with disabilities, Eyles said, adding that it "does nothing to lower prescription drug prices."

"While we continue to urge full withdrawal of the prior Administration's rule, this delay will allow Medicare Part D plans in 2022 to provide the benefits and premiums seniors have come to expect," Eyles concluded.

Ge Bai, Ph.D., an associate professor at Johns Hopkins University's Carey Business School and Bloomberg School of Public Health, says that "there are two reasons the rule was established: One was to reduce patient cost sharing at the pharmacy counter. Second would be to optimize PBMs' product selection, so that they would put more cost-effective drugs in their formulary."

Bai observes that PBMs don't always put the drug that would be cheapest to consumers into a formulary. Instead, PBMs may choose a drug whose manufacturer offers the PBM a more generous rebate than the competition, even if it's a pricier brand-name drug.

The bottom line, Bai says, is that "there's a tradeoff between premiums and patient cost sharing. Rebates that come back [to insurers and PBMs] will reduce premiums, but patients who actually use the drug won't see savings at the pharmacy counter from the rebates.…You can't have both."

Congress Is in Need of an Offset

In any case, politics could mean the legality and impact of the rule may be a moot point. Dan Mendelson, founder of Avalere Health, tells AIS Health that the balance of power in Congress creates a strong incentive for the rule to be repealed by legislators.

"Because the Senate is so tight, one of the only ways to get things through is this budget reconciliation process," Mendelson explains. "Budget reconciliation gives you a world where you can pass with 50 votes in the Senate — but it comes along with liability that new programs have to be fully offset; you have to have cost reductions that you pass at the same time. And so, as a result, there's an all-out scramble for cost reductions that could be layered into a reconciliation bill to make the whole thing work."

Mendelson adds that repeal of the rebate rule is a tantalizing opportunity for lawmakers under those circumstances. Since the rebate rule would be costly but hasn't actually been implemented, eliminating it would create a massive savings on paper without the political cost that would come from cutting a real program of similar scale.

"It's a cute trick if you can repeal a regulation and score a savings even though nothing happened. It is truly a budget gimmick of the highest order," Mendelson says.

However, Mendelson says that the drug pricing issue won't end with the repeal of the rebate rule. He expects this Congress to take up the matter at some point with support from the

administration. "The problem with using pharmaceutical policy as a cost offset is what you really want to do is reduce the out-of-pocket spend for consumers," Mendelson observes. "And that's frankly what people want, and it is ultimately the only solution to this. You don't want to take those savings and then just shovel them back into Medicare cost offsets. You want to solve the problem."

Mendelson expects that conversation could include changes to Medicare and Medicaid's drug pricing models.

"Trump and Biden have similar positions on drug pricing policies, particularly as it relates to differences between drug prices in the U.S. compared to other countries," Lance Grady, practice leader for market access at Avalere Health, tells AIS Health via email. "Specifically, President Biden's platform includes allowing for drug importation from other countries, allowing Medicare to negotiate drug prices, and establishing a drug price review board for new high-cost drugs that would recommend a price based on the drug's value and the average price paid in other countries. Because Medicare negotiation/international reference pricing is unlikely to get enough votes to pass in Congress, the Biden Administration may also look to [the Center for Medicare and Medicaid Innovation] to implement Medicare negotiation via international reference pricing and/or a drug price review board."

Indeed, the Trump administration tried a similar approach through executive action, finalizing a rule in November 2020 that would have tied Medicare Part B drug prices to the cost of pharmaceuticals in other countries. Two federal judges have issued injunctions to block implementation of that rule, which was meant to be phased in as a model starting on Jan. 1, 2021.

In a similar way, Bai says that the rebate rule was ultimately done in by its association with Trump — even though many Democrats dislike the PBM rebate model.

"I think that, politically, the new administration probably won't want to be perceived as continuing these policies," Bai explains. "The rebate rule has a very Trump flavor."

Read the court order at https://bit.ly/3rrcy4r. Contact Bai at gbai@jhu.edu, Grady and Mendelson via Liz Moore at lmoore@avalere.com and Sachs at rsachs@wustl.edu. ✧

by Peter Johnson

News Briefs

✦ ***UnitedHealth Group will make Optum CEO Andrew Witty its next CEO, succeeding retiring CEO David Wichmann, who has held the top job since 2017.*** Witty has run UnitedHealth's PBM, hospital, finance and data analytics subsidiary since 2018, and previously served as CEO of pharmaceutical manufacturer GlaxoSmithKline plc from 2008 to 2017. During the COVID-19 pandemic, Witty "took an unpaid leave of absence from his company positions to serve as a Global Envoy for the World Health Organization's COVID-19 efforts" and "served as an advisor to the UK Government Vaccine Taskforce," according to a press release. Dirk McMahon will become the company's new president and chief operating officer. Read more at http://bit.ly/3oPigeW.

✦ ***President Joe Biden on Feb. 2 signed an executive order on immigration that called for a review of the Trump administration's so-called "public charge rule."*** The rule allowed immigration officials to consider use of Medicaid coverage and other non-cash benefits in reviewing applications for legal residence. Although the regulation was tied up in litigation before its February 2020 implementation, research showed it still caused enough confusion and fear among immigrants to prevent them from enrolling in Medicaid. Estimates of the potential negative impact of the public charge rule on Medicaid enrollment range from about 1 million to more than 4 million, wrote Evercore ISI analyst Michael Newshel on Feb. 2. "The Biden administration has been expected to rescind the rule, which is positive for Medicaid MCOs and also hospitals." Read the order at http://bit.ly/3pQagvw.

✦ ***Anthem, Inc. will acquire MMM Holdings, LLC, Puerto Rico's largest Medicare Advantage plan and second-largest Medicaid plan, from InnovaCare Health, L.P.*** MMM has "more than 267,000 MA members and over 305,000 Medicaid members," according to a Feb. 2 Anthem press release. MMM, an integrated care organization, also "includes more than 10,000 healthcare providers and more than a dozen offices across Puerto Rico," the release said. Puerto Rico's regulatory authorities have yet to review the deal. Read more at http://bit.ly/39Pg82I.