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Centene Boosts Behavioral Health Offerings With Magellan Buy

Following the recent acquisition of PANTHERx Rare, LLC and the first-quarter 2020 addition of WellCare Health Plans, Inc., Centene Corp. kicked off the new year with an agreement to purchase Magellan Health, Inc. for $2.2 billion. Magellan also just completed the previously disclosed sale of its managed care division to Molina Healthcare, Inc. The newer transaction will allow Centene to expand its behavioral health platform, increase its specialty health and pharmacy capabilities and enhance its ability to address members' whole health.

During a Jan. 4 conference call to discuss the planned transaction, Centene Chairman, President and CEO Michael Neidorff said the combination is in line with the company's diversification strategy and boosts Centene's capacity to "provide comprehensive care to the most complex and vulnerable populations," especially as it relates to behavioral health care.

"There are significant gaps in today's health care system as it relates to behavioral health, delivering suboptimal outcomes for patients while creating significant financial cost to the health care system," he continued. And integrating behavioral health into the whole treatment of a patient has the potential to reduce costs and improve care quality, he suggested.

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2021 Outlook

COVID Will Have Lasting Impact on MAO Investment Targets

With a new administration that will be focused on the COVID-19 pandemic and improving health care coverage, industry experts do not anticipate major changes to the Medicare Advantage program, although many agree the pandemic will leave a lasting impact on the industry. And as President-elect Joe Biden looks to expand coverage, MA will likely be held up as a "successful example of a public-private mechanism to take Medicare eligibility to age 60," predicts Wunderman Thompson Health's Lindsay Resnick.

For AIS Health's annual roundup of predictions about the year ahead for MA organizations, numerous experts weigh in on how doing business in 2021 might look different than in previous years.

What do you view as MA insurers' "keys to success" in 2021?

Steve Arbaugh, managing principal and CEO, ATTAC Consulting Group: "One of the major keys remains developing effective responses to the ongoing COVID-19 situation, which has many, many impacts. Areas of focus will be supporting immunization efforts in the [next six to nine] months; plans can work with their partners such as major drug store chains (as supplies become available) and as part of their consumer engagement strategies to support getting enrollees vaccinated through transportation and other means.

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"At the same time, with the increase in isolation and pandemic exhaustion, there has been an increased demand for behavioral health services; this may pose a challenge for access that plans need to address with their networks. Plans may want to consider conducting internal mental health program reviews and parity mock audits.

"Third, on the COVID repercussions, [there] are changes that plans (and their vendors) may have to make to address reduced/delayed physician visits and their impact on diagnosis capture and patient treatment. This will require plans to really have strong data sets on gaps in care and treatment, and take action early in the year since it will impact both HEDIS data and risk adjustment data to get patients engaged with their providers — even through virtual telehealth sessions. It may be harder to maintain 4.5 and 5 STAR ratings for plans."

Dan Mendelson, founder, Avalere Health: "Managing patient experience during the pandemic was a key differentiator in 2020. With insured people less likely to seek primary care, plans still had to figure out ways to engage patients and deliver care [that was] necessary — particularly the preventive care that drives star ratings. Many MA plans also stepped up and furthered their programs around social determinants of health, which were highly valued by consumers during the pandemic."

Patrick Phillips, CEO, Cavulus: "The pandemic has shone a bright floodlight on the necessity of technologies that enable remote work. COVID exacerbated this need by forcing work from home, but MA plans always rely on geographically disparate entities for essential operations — particularly in marketing, sales and enrollment. MA plans will only maximize success when they have complete insight and total control over data generated across staff in corporate offices, in the field, working from home, in third-party call centers, and so on.

"Given CMS bid requirements, plan premiums and benefits are often similar among competitors. So, member experience has become foundational. Many plans still have enrollment processes that feel bureaucratic and impersonal, so plans need to take an honest look at the technology, talent, and training needed to make improvements."

Lindsay Resnick, executive vice president, Wunderman Thompson Health: With the Medicare population on deck for the next distribution phase of COVID-19 inoculations, "MA plans have to be visible and effective with outreach and engagement on COVID vaccinations with their members: removing myths, reinforcing credibility and guiding logistics. In short, their role in 2021 is to be a steward of public health to 'educate, motivate and activate' America's seniors."

Second is primary care. "We're seeing a boom in collaboration between MA plans, and primary care delivery systems and I expect this trend to continue to take hold in 2021. Examples include primary care providers such as ChenMed, Iora, Oak Street and Sanitas aligning with MA plans from Blues to regionals to mega-MA nationals. We're also seeing similar activity from Walgreens and Walmart."

Finally, "[w]hile there are a number of MA upstarts looking to make noise as 'disruptors' [e.g., Clover Health, Oscar Health] at the end of the day, they are insurance companies selling Medicare coverage. I believe the challenge for these, and all second- and third-tier MA plans, is carving out a value proposition enough to go head-to-head with big-budget national MA players that hold upwards of 75% market share. These MA plans must be unique, compelling and offer a value exchange that resonates with prospective members at the local community level."

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What critical investments do you expect MA insurers to make this year and why?

Arbaugh: "2021 has [been] and we expect 2022 to continue to be years of plan expansion. While some provider-sponsored plans may have delayed getting into the market because of financial challenges brought on by COVID with their parent health systems, we see the major national and regional players continuing to expand, and so positioning for enhanced competition will mean developing both better networks and enhancing customer engagement."

Abner Mason, founder and CEO, ConsejoSano: "With elective care postponed during the pandemic, Medicare Advantage plans should have a pretty good-sized pot of cash available for investment, and I believe much of that is going toward mitigating social determinants of health (SDOH) barriers. Plans that are able to invest those SDOH dollars into interventions for their members are going to see a return on investment in the form of lower expenses and fewer hospital visits, i.e., better health outcomes.

"More broadly, 'innovation and equity' will be the name of the game in 2021. People say that every year, but 2021 has some interesting data points that suggest a new direction for managed care. More people will be enrolled in Medicare this year than ever in the history of the program, but we're just getting warmed up. We'll see another 10 million enrollees in the next five to six years, so there's a huge impetus to start figuring out now how to control costs and maintain or improve outcomes, and that will drive innovation. We have Medicare Advantage clients who depend on us to help them understand their members and how to best engage them, and what we are seeing is a growing segment of Medicare enrollees who are multicultural, which will affect costs and approaches as well."

Mendelson: "Plan operations in 2021 will continue to be dominated by the pandemic. With the winter surge in cases, and many hospitals overwhelmed, expect to see more challenges engaging consumers and in primary care, and plans will need to invest as such. Plans are also increasingly making investments to deploy analytics to improve care management in critical areas — including behavioral health, post-acute care and pharmacy."

Kevin Palamara, managing director, and Jake Vesely, senior analyst, Provident: "Starting in 2021, payers and hospice providers will have the option to participate in the [CMS Center for Medicare & Medicaid Innovation] Value-Based Insurance Design Model, providing coverage for hospice and palliative services through MA plans. Payers offering MA plans would greatly benefit [from] seeing patients opt for hospice and palliative services, rather than more costly treatments for end-of-life care. Payers, such as Humana and Anthem through their acquisitions of Kindred and Aspire Health, are exploring [mergers and acquisitions] as an opportunity to vertically integrate and to have a greater influence on the appropriate treatment path for patients receiving end-of-life care.

"This integration of payers and hospice providers offers a clear synergy, from both a top and bottom-line perspective, and we anticipate this trend to continue as more payers and hospice providers participate in the carve in" of hospice in MA.

Phillips: "In light of the pandemic, forthcoming changes to the risk adjustment model, and a permanent easing of telehealth regulations, we're already seeing investments in tele/virtual health and expect that to continue. With member experience becoming such a critical differentiator, some insurers who've paused IT decision-making have to jumpstart the replacement of antiquated infrastructure in areas such as enrollment, claims, and appeals and grievances since they impact members directly."

Resnick: "While the pandemic already changed the game of telemedicine, pushing that health delivery niche up the maturity curve faster than we could imagine, expect similar growth trajectories in a number of other 'at-home' mature market health services including remote monitoring, pharmacy, M.D. or nurse practitioner house calls, and in-home loneliness prevention."

How do you think 2020 permanently changed sales and marketing for MAOs?

Diane Hollie, vice president, sales, marketing and strategy with Gorman Health Group: "I believe that with the increase in digital because of what has occurred with the pandemic, digital is going to be if not No. 1 then the No. 2 marketing tactic for 2021. As we're starting to see, the aging-in member today is very, very different from five years ago, and night and day from 10 years ago. The majority of those who are aging into Medicare now are very savvy from utilizing their phones and working on the web; it's what they do. That's how business is conducted today. These people have a very different outlook and respond to things very differently than those from even five years ago. So in the under 65 market, we saw that [transition to] digital happen very quickly, and with the over 65 it's taken a very long time for that to start, but I think this pandemic has really forced the issue with online and digital."

Resnick: "I'm not sure we'll ever go back to in-person seminar selling, certainly as prominent a sales channel as it was pre-pandemic. Bad donuts and overt sales pitches at the local motel may be gone forever! The surge leveraging digital channels to educate and sell MA will continue, as will growth of 'EMOs' (Electronic Marketing Organizations). Not to worry anyone, but at 56 million Americans over age 65 and growing, how long do you really think it will be until Amazon jumps into Medicare sales?"

> **Bad donuts and overt sales pitches at the local motel may be gone forever!**

Lastly, what do you think we can expect in terms of program enforcement?

Michael Adelberg, principal, Faegre Drinker Consulting: "The last time a Democrat administration replaced a Republican, there was a significant ramp-up of MA plan oversight activities. 2021 is not 2009 — MA is a more mature program and plan conduct is better than it was in 2009. But I'd still look for a Biden-run CMS to tighten its oversight MA processes in select areas — risk adjustment, provider networks, and marketing are good bets."

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MCOs Mull Managing Care for Duals in FFS Medicare Demo

With the aim of improving care for dual eligible individuals while promoting value-based care in fee-for-service Medicare, CMS last month introduced a new option for certain Medicaid managed care organizations to become Direct Contracting Entities (DCEs) that will coordinate care and share risk for duals who access their Medicare benefits through FFS. But some MCOs have questions about the design of the model, and one organization warns that the arrangement could have a detrimental impact on accountable care organization (ACOs) that have made significant investments in value-based care.

Model Promotes Value-Based Care

Starting Jan. 1, 2022, CMS will test whether holding these entities accountable for health outcomes and Medicare FFS costs for their full-benefit dually eligible Medicaid MCO enrollees will lead to innovative strategies for improving care for this high-risk population. Operated by the CMS Center for Medicare & Medicaid Innovation (CMMI), the overall aim of the Direct Contracting Model is to "test financial risk-sharing arrangements to reduce Medicare expenditures while preserving or enhancing the quality of care furnished to beneficiaries," according to a Dec. 17 press release from the agency. And a key tenet of that program is inviting a variety of different organizations to participate in value-based care arrangements in Medicare FFS.

To be eligible for the 2022 performance period, these new MCO-based DCEs must be either an MCO that has a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) or Medicare-Medicaid Plan contract with CMS; or they may be affiliated under common ownership with an entity that has the FIDE SNP or MMP contract with CMS. In addition, they must cover long-term supports and services (LTSS) — specifically taking risk for nursing facility costs — and/or behavioral health services for people with serious mental illness/substance use disorder, unless the state's managed care program excludes such individuals.

Plans Have Two Risk-Sharing Options

There are three other types of DCEs, which are largely provider-based organizations and were included in the first phase of implementation that began on Oct. 1, but this marks the first time CMS has explicitly invited MCO-based DCEs to participate. Similar to legacy ACO models such as the Medicare Shared Savings Program or the Next Generation ACO Model, the Direct Contracting Model offers participants two risk-sharing options: (1) the lower-risk Professional Option, in which CMS and DCEs split savings or losses; and (2) the Global option, in which entities take full risk.

However, as the National Association of Accountable Care Organizations (NAACOS) argued in a Dec. 16 letter to CMMI Director Brad Smith, the model does not provide an "equitable opportunity" to providers that were at the forefront of value-based care and have experience serving FFS beneficiaries. It "has been steered increasingly to incentivizing new entrants into Medicare and, in some ways, adding a new administrative layer," wrote NAACOS President and CEO Clif Gaus before CMS had even unveiled the new MCO-based option. He said the current financial specifications will "disenfranchise legacy ACOs that have worked for nearly a decade."

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2021 Outlook

COVID Vax, State Budget Issues Add to Medicaid MCOs' Urgency to Address Disparities

As the novel coronavirus erupted across the U.S. and created a widespread economic downturn, it led to increased enrollment in state Medicaid programs and created devastating budget shortfalls for states. Yet Congress' latest pandemic relief effort — the Consolidated Appropriations Act signed by President Donald Trump on Dec. 27 — does not include direct financial help for states, which are now rolling out newly authorized COVID-19 vaccines with limited resources and guidance from the federal government.

Earlier legislation, the Families First Coronavirus Response Act, afforded states a temporary increase of 6.2% in their federal match rate, yet multiple stakeholders including managed care plans have beseeched Congress to enact another temporary boost during the public health emergency.

In a Dec. 14 letter to President-elect Joe Biden, Medicaid Health Plans of America President and CEO Craig Kennedy said that securing an additional Federal Medical Assistance Percentage (FMAP) increase of at least 5.8% (for a total increase of 12%) remains the trade group's top legislative priority. A growing reliance on state Medicaid programs for coverage coinciding with "unprecedented state budget pressures" could result in "deep cuts which will have severe impacts on Medicaid agencies, providers, and beneficiaries that rely on the program for high quality coverage and care," he warned.

"MHPA's members continue to see states propose and enact unsustainable rate cuts and harmful risk corridors, which threaten the continued viability of state-managed care partnerships," Kennedy continued. To minimize disruptions in care, MHPA urged the incoming administration to immediately extend the public health emergency beyond its Jan. 20 expiration date and enact an additional FMAP increase at least through September 2021.

"There is no question that the new administration will push hard to increase funding for state Medicaid," predicts Avalere Health Founder Dan Mendelson. "Generally, the new administration will want to expand coverage and work with the states to get that done."

Jerry Vitti, CEO and founder of Healthcare Financial, Inc., agrees that making states whole will be a Biden priority. "This is not a blue state/red state divide. Every state has these problems, and it's the double whammy of the decreased revenue at a time where your expenses are going way up because people need social services programs, they need Medicaid, their health care systems are strained, they have to distribute vaccines — all these associated costs need to be covered."

Meanwhile, as the COVID-19 pandemic has highlighted so many disparities in health care, Medicaid MCOs will be expected to take concrete action to bridge care gaps, especially in communities of color.

"With people of color comprising over half of Medicaid enrollees, 2020 has been a reckoning: COVID-19 and health disparities have made it so much more deadly for them. We've seen a large-scale public response that has made it pretty clear that these kinds of outcomes are no longer acceptable. Medicaid MCOs will need to innovate to address equity issues," says Abner Mason, founder and CEO of ConsejoSano, a health tech startup that specializes in linguistically and culturally aligned Medicaid and Medicare patient outreach for health plans and health systems.

"Interestingly, I think as Medicaid plans invest money upfront into innovative solutions that reduce disparities for underserved communities, they'll see those outcomes improve and see larger-than-expected savings in the end. Hopefully, those savings will be funneled into further offerings," he adds.

In addition to greater investments in social determinants of health, Vitti predicts "more widespread adoption of telehealth, and appropriate reimbursement for telehealth," whether members are in a rural or urban setting. And with more people seeing and engaging with their doctors, telehealth has the potential to increase member engagement, in turn allowing health plans to better manage their care and overall costs, he suggests.

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Medicaid MCOs Mull Duals Demo

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NAACOS requested that CMMI make several changes to how it determines rewards and penalties, including revising the DCE benchmark methodology so that earlier years of experience have a higher weight. Gaus also pointed out that "it is unclear if some organizations who look to enter FFS Medicare for the first time are doing so with the goal of gaining exposure to beneficiaries to then recruit them to Medicare Advantage."

Plans Weigh Potential Merits of Demo

SCAN Health Plan, which currently operates the only FIDE SNP in California, says it is still assessing the opportunity.

"We're a managed care plan, so of course we believe that financial alignment is important, and through the many years that managed care has existed, we think many of us have gotten really good at delivering high quality care and managing the right care for the right people at the right time. So we're excited about this opportunity, but we're still concerned [about] whether the incentives are aligned," says Eve Gelb, senior vice president of health care services with SCAN.

Gelb points out that the model as described by CMS appears to be geared toward encouraging provider participation and may be "a little lax on the beneficiary protections." Although MCOs can explain how they'll maintain beneficiary protections in their applications, Gelb is "concerned that the financials might align to underutilization and things that happened, frankly, when managed care began," she tells AIS Health. "So the question is, how can we learn the lessons of early managed care so that we don't repeat mistakes and get to real quality?" At the same time, there's the question of whether this will be another option for duals in an already complex landscape of care delivery that has the potential to confuse people, she says.

How Will Beneficiaries Be Protected?

"There are so many different ways to serve a population, so I love that CMMI and others are thinking through innovation because there's not one silver bullet. But everything that moves to more integrated care, I think, is better in terms of behavioral integration, with physical health, with long-term services and supports — as long as there are the right beneficiary protections in place," adds Gelb.

"Any approach that can possibly improve outcomes is worth exploring, and we appreciate the willingness of CMS to try different models like this," echoes Chris Palmieri, president and CEO of Boston-based Commonwealth Care Alliance (CCA), one of the largest and top-rated MMPs in the U.S. Although the DCE model has the potential to improve duals' care, "it's far too early to tell as the requirements around integration of benefits, quality standards, etc. have yet to be defined," he says. "CCA has been fortunate to effectively operate in this environment for some time, but a national view reveals mixed outcomes for organizations operating integrated MMPs/FIDE-SNPs. The potential for success of CMS's expanded Direct Contracting Model will be predicated on keeping the bar high regarding an organization's capacity to navigate across both benefits and show a track record of improving quality, all while being a strong fiscal steward for state Medicaid agencies and CMS."

CMS expects to release a request for applications for all DCE types in early 2021 for participation in 2022. An agency fact sheet outlined several actions MCO-based DCEs could take to better serve duals. These include:

- ***Establishing processes to connect aligned beneficiaries to a primary care provider,*** particularly high-value Medicare FFS health care providers;
- ***Risk-stratifying and targeting care coordination resources toward aligned beneficiaries*** at risk of high Medicare spending; and
- ***Entering into value-based purchasing arrangements with nursing facilities*** that factor in these facilities' hospitalization rates.

Visit https://go.cms.gov/3rnD0gc. View the NAACOS letter at https://bit.ly/3pBag25. Contact Gelb via Michelle Millsap at michelle.millsap@havasformula.com or Palmieri via Conor Yunits at cyunits@solomonmccown.com. ✧

Centene Will Buy Magellan Health

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Magellan will operate as an independent company, and the combination of the two entities will "establish one of the nation's largest behavioral health platforms across 41 million unique members with enhanced capabilities to deliver better health outcomes for complex, high-cost populations," according to a Jan. 4 press release. Magellan also brings with it 5.5 million new members on government-sponsored plans, and it provides specialty health services to 18 million third-party customers in addition to Centene's own members. Neidorff suggested that will create opportunities to drive growth, enhance internal operations, cross sell and increase engagement with third-party customers.

The deal also creates additional value across pharmacy capabilities, adding more than 2 million pharmacy

benefit management (PBM) customers and 16 million medical pharmacy lives, said Centene Chief Financial Officer Jeff Schwaneke.

"As the leader in government-sponsored health care, including medically complex populations, having this capability in house enables us to better understand the specialty pharma pipeline, clinical requirements and cost management aspects," he said. It also creates additional engagement opportunities that Centene expects will lead to "better adherence rates and ultimately, improved patient outcomes."

In a Jan. 4 research note on the transaction, Jefferies analysts called the $95 per share cash deal a "reasonable price" for Magellan shareholders but pointed out that, "[w]hile the transaction enhances CNC's behavioral health, specialty healthcare (i.e. radiology, oncology), and PBM businesses," it will only be accretive to earnings per share in year two after realizing $125 million of cost savings.

Centene has been on an acquisitive tear in recent years, building up its Medicaid and Medicare businesses with the additions of HealthNet in 2016, Fidelis Care in 2018 and WellCare in 2020, which nearly doubled its MA membership (see table, p. 8). The insurer last month also purchased PANTHERx, a specialty pharmacy that specializes in orphan drugs and rare diseases. Centene, Magellan and PANTHERx combined will deliver approximately $22 billion in revenue.

The Magellan transaction is subject to regulatory and other closing conditions, and is expected to be completed in the second half of this year.

Contact Jefferies analyst David Windley at dwindley@jefferies.com.

Visit https://investors.centene.com. ✧

News Briefs

✦ ***Humana Inc. in a new lawsuit alleges that Kentucky violated its five Medicaid contracts by allowing Molina Healthcare, Inc. to acquire the Medicaid membership of Passport Health Plan, reports Louisville Business First.*** After reviewing a second round of bids, Kentucky Gov. Andy Beshear (D) and the Cabinet for Health and Family Services last May named the same five winners in the Medicaid contract awards originally made under former Republican Gov. Matt Bevin *(RMA 6/4/20, p. 4)*. Incumbent bidder Passport, which at the time was on the brink of insolvency, was not chosen. Molina, which was selected for a new contract, acquired Passport's approximately 315,000 Medicaid members in Kentucky on Sept. 1, 2020. But in a lawsuit filed Dec. 23, 2020, Humana questions whether the takeover entitled Molina to Passport's membership for a new contract period and asserts that Passport "had no claim to its membership at all beyond its contract" that expired on Dec. 31, according to the business journal. Anthem, Inc., which also was not selected as one of the initial five MCOs, contested the awards and in October won a temporary injunction directing the state to make it the sixth participant. Visit https://bit.ly/3rXRV0U.

✦ ***Independence Blue Cross and Strive Health this month launched a new initiative to bring specialized care delivery and coordination to Independence Medicare Advantage members living with chronic kidney disease (stages 4 and 5) and end stage renal disease.*** The program aims to slow disease progression and improve quality of life for these members by assisting with care management and reducing unnecessary hospital stays, according to the Philadelphia-based insurer. Eligible members will receive care from Strive Health's local team that includes nurse practitioners and dietitians, and will receive direct and virtual clinical services, home dialysis education and training, advanced care planning, and help with social determinants of health. Contact Diana Quattrone at diana.quattrone@ibx.com.

✦ ***As Medicare and Medicaid plans seek ways to address social determinants of health for complex populations, Papa recently unveiled the national expansion of its elderly companionship services and a new comprehensive health management platform.*** The new Papa Health platform offers virtual primary care, urgent care and chronic care management to its members. Papa is also launching an app that will enable Papa Pals to "more efficiently plan visits and build stronger connections" with members, according to a Jan. 5 press release. The Miami-based company currently counts Aetna, AvMed, Florida Blue Medicare, Humana, Priority Health and Regence Blue Shield among its growing roster of plan partners. Visit https://bit.ly/2Msctyi.

Top 25 Medicare Advantage Insurers as of December 2020, With Year-Over-Year Change

by Carina Belles

The top 25 Medicare Advantage insurers enroll a combined 21.6 million lives, or 87.0% of the national market, according to the December 2020 update to AIS's Directory of Health Plans. That's up from 84.1% market share at year-end 2019. Seniors have increasingly flocked to MA in recent years, and insurers have expanded their geographic footprints and benefit options in response. In 2020, nine of the top payers saw growth of more than 10%, with Centene Corp.'s completed acquisition of WellCare Health Plans, Inc. allowing its MA business to nearly double in size to more than 800,000 lives. See the table below for the complete list of the top 25 MA payers.

Insurer	Service Area	No. of Contracts	2020 Enrollment	Change From 2019
UnitedHealthcare	Nationwide	68	6,458,827	8.3%
Humana Inc.	Nationwide	43	4,523,732	11.4%
Aetna	Nationwide	42	2,631,411	14.7%
Kaiser Permanente*	Seven regional MCOs	8	1,711,466	2.6%
Anthem, Inc.	Nationwide	28	1,382,828	18.2%
Centene Corp.**	California, Florida, Texas and 28 other states	64	845,460	170.1%
Blue Cross Blue Shield of Michigan	Michigan and nationwide	2	585,540	12.5%
Cigna Corp.	Florida, Tennessee, Texas and 17 other states	14	522,660	19.0%
InnovaCare Health Solutions	Puerto Rico and Florida	4	262,869	-0.4%
Highmark Health	Pennsylvania, West Virginia and 34 other states	3	231,986	5.7%
SCAN Health Plan	California	3	218,864	7.1%
Healthfirst	New York	2	203,201	18.6%
UPMC Health Plan	Pennsylvania	3	195,465	1.5%
Priority Health	Michigan	3	185,831	19.5%
Medical Card System, Inc.	Puerto Rico	1	180,650	8.1%
BlueCross BlueShield of Tennessee	Tennessee	2	159,242	6.9%
Florida Blue	Florida	3	151,734	13.4%
Blue Shield of California	California	3	144,426	2.8%
Blue Cross and Blue Shield of Minnesota	Minnesota	2	141,376	4.7%
Triple-S Management Corporation	Puerto Rico	2	134,178	6.6%
Excellus BlueCross BlueShield	New York	2	133,194	2.7%
HIP, an EmblemHealth Company	New York	2	126,050	3.3%
Medica	Minnesota, South Dakota, Wisconsin and four other states	6	113,306	8.7%
UCare	Minnesota	4	109,235	1.4%
Tufts Health Plan	Massachusetts	1	104,105	1.7%

*Enrollment figures represent the sum of Kaiser's seven regional managed care organizations.
**Enrollment data includes Centene's acquisition of WellCare, which closed in January 2020.
SOURCE: DHP, AIS's Directory of Health Plans