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MA Insurers Step Up SNP Offerings for 2022, Particularly for Duals

As Medicare Advantage enrollment soars and the number of individual MA plans available across the U.S. reaches a new high for 2022, the MA Special Needs Plan market is also seeing continued growth. According to estimates from Clear View Solutions, LLC, there will be 926 plans available next year that were offered in 2021, compared with 766 plans that carried over from 2020 to 2021 (see infographic, p. 6). Dual Eligible SNPs (D-SNPs), in particular, will rise from 477 plans offered in 2020 and 2021 to 569 plans available this year and next, according to the consulting firm's analysis of the 2022 SNP Landscape files from CMS.

A recent Kaiser Family Foundation assessment of 2022 plan offerings observed that more MA plans will be available next year than in any other year, reaching a total of 3,384 individual plans, and that the average beneficiary will have 39 MA plans to choose from, up from 33 choices in 2021. That analysis excluded SNPs, group MA plans and PACE plans that are only available to select populations.

Cheryl Phillips, M.D., president and CEO of the SNP Alliance, says it's not surprising to see an increased number of SNP offerings for 2022, and that's for several reasons, starting with the CHRONIC Care Act. Included in the Bipartisan Budget Act (BBA) of 2018, the CHRONIC Care Act granted permanent authorization to SNPs, which at the time served more than 2.5 million enrollees. The plans were authorized under the Medicare Modernization Act of 2003 to serve institutionalized, dual-eligible or severe/disabled chronically ill patients through 2008, and they went through a series of brief reauthorizations before the BBA cemented their place in MA. More than 4.1 million individuals are now enrolled in a SNP, of which nearly 3.7 million are in a D-SNP, according to the latest update to AIS's Directory of Health Plans.

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Given COVID Surge, Humana Deviates From Peers With Lower Guidance

Like the other publicly traded insurers that reported third-quarter 2021 earnings late last month, select Medicare Advantage insurers in early November demonstrated strong performances during a quarter that was tainted by a rise in COVID-related costs. Unlike its more balanced peers, however, MA-focused Humana Inc. took a decidedly conservative approach to projecting earnings for the full year given continued COVID uncertainty.

For ***Cigna Corp.***, total medical costs came in higher than expected with an overall medical loss ratio (MLR) of 84.4%, while there were sequential improvements in both the commercial and MA lines of business, the company reported on Nov. 4. During a conference call to discuss recent quarterly earnings, Cigna Chief Financial Officer Brian Evanko said that medical costs were "driven largely by the impact of the Delta variant in our U.S. commercial business and increased medical

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costs for special enrollment period customers in our U.S. individual business," per a transcript from The Motley Fool. He reminded analysts that approximately 80% of Cigna's revenues come from service-based businesses that are not significantly impacted by medical cost fluctuations.

Adjusted revenue for the quarter of $44.3 billion and adjusted earnings per share (EPS) of $5.73 exceeded the company's expectations, reflecting growth across all business segments, according to Evanko. Cigna this year has added 368,000 members, driven by "net growth in select and new markets within U.S. commercial and continued organic growth in Medicare Advantage and individual within U.S. government," he added. The company, which does not break out MA membership numbers in its earnings reports, said the government segment served 1.5 million members as of Sept. 30, compared with 1.4 million a year ago.

Recognizing the "ongoing fluidity of the broader environment," Evanko explained that the company raised its adjusted EPS expectations by about 15 cents to at least $20.35. That reflects growth of at least 10% from 2020, consistent with Cigna's long-term EPS target growth range of 10% to 13%. Cigna also projected a 2021 MLR range of 84.0% to 85.0%.

In earnings posted Nov. 3, ***Humana*** beat Wall Street's estimated $4.66 per share with an adjusted EPS of $4.83, compared with $3.08 recorded in the third quarter of 2020. Its MLR also came in slightly better than consensus at 87.1%, compared with 82.6% in the year-ago quarter.

Humana lowered its adjusted full-year EPS guidance to approximately $20.50 (compared with a previous estimate of $21.25 to $21.75), representing expected adjusted EPS growth at the lower end of its long-term target, explained Bruce Broussard, president and CEO, during a Nov. 3 earnings call. That $1 decrease in anticipated earnings is largely the result of COVID and the company's expectation that overall MA utilization (including COVID costs) will run closer to "baseline" than it formerly predicted.

The company in July said its 2021 guidance assumed that non-COVID MA utilization would be about 2.5% below baseline in the second half of the year, with minimal COVID testing and treatment costs for the same period. But after the September surge in COVID cases due to the Delta variant, Humana said it now expects non-COVID MA utilization to run 5.5% below baseline in the second half of the year, "while being partially offset by 3 percent of COVID costs."

"Our revised guidance does not assume that the higher levels of favorable current period development seen in the third quarter will continue. Taken together, our updated full year 2021 adjusted EPS guidance takes a more conservative posture going into the final months of 2021, and it's important to note, as we've consistently shared throughout the year, the midpoint of our original guidance range of $21.50 remains the correct baseline for 2022 given our approach to pricing," stated Chief Financial Officer Susan Diamond, according to a transcript of the call from The Motley Fool.

Is 4Q Earnings Concern Just 'Noise'?

"Admittedly the numbers are difficult to reconcile given [the] high percentage of vaccinations among the MA population, and implied 4Q assumptions will be a source of questions," observed Citi analyst Ralph Giacobbe in a Nov. 3 note to investors. "On the positive side the company continues to point to $21.50 as the right baseline to consider growing off of for 2022, potentially making 4Q/2021 guidance more noise than anything."

Regarding membership growth, Humana expects to add 450,000 individual MA members for the year,

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which is the midpoint of its previous guidance of up to 425,000 to 475,000 members, representing "above market growth" with an increase of 11.4% from 2020, added Diamond. Humana reported serving nearly 4.4 million individual MA members as of Sept. 30.

Looking ahead to 2022, the insurer is projecting MA enrollment growth of 325,000 to 375,000, representing a year-over-year increase of 8% and reflecting Humana's "prudent approach" to MA bids for 2022 and "the competitive nature of the market," Diamond said. Broussard noted that Humana has had outsized membership growth of 40% in its Dual Eligible Special Needs Plans, which add enrollees throughout the year and will be available to nearly 65% of the dual eligible population next year.

In pricing its products for 2022, Humana prioritized "long-term benefit stability" for members, said Broussard. "While it is early in the selling season, we believe we struck the right balance and are competitively positioned for

Clover Health Struggles to Contain Medical Costs for Medicare Advantage Members

Of the newly public startup insurers that reported third-quarter 2021 earnings, all four posted higher (worse) medical loss ratios (MLRs) compared with the prior-year quarter — a direct result of higher COVID-related costs. The two insurers with a focus on Medicare Advantage, however, demonstrated wildly different experiences, with Clover Health Investments Corp.'s MLR clocking in at 102.5%, while Alignment Healthcare, Inc.'s 85.7% MLR was more in line with those of the larger, established insurers (see story, p. 1).

Reporting quarterly earnings for the third time since going public in January, Clover recorded an MA MLR of 102.5%, an improvement over the 111.0% it recorded in the second quarter of 2021 but worse than the 86.7% it posted in the comparable 2020 quarter. That was using the generally accepted accounting principles (GAAP) measure that is required in financial statements. As was the case for many insurers, the year-over-year increase was largely due to COVID-related costs and increased utilization from deferred outpatient care. Meanwhile, Clover attributed its sequential improvement to "operational efficiencies, a decline in direct COVID costs, and seasonal trends."

On a "normalized" basis (i.e., non-GAAP, without COVID), MLR for the quarter would have been 94.8%, compared with 96.3% in the second quarter and 96.4% for the third quarter of 2020, estimated the company. Clover also posted a net loss of $34.5 million for the quarter, compared with net income of nearly $12.8 million in the year-ago quarter.

Although Clover's total revenues of $427 million beat the Wall Street consensus estimate of $413 million and its MLR showed sequential improvement, the high "absolute percentage" still gave Citi analyst Ralph Giacobbe pause. "We have updated our model lowering our revenue estimates as we take a more conservative view of direct contracting enrollment, and raise our MLR to reflect initial guidance," Giacobbe wrote on Nov. 9.

Reflecting a year-over-year increase of 153%, Clover's overall revenue consisted of $204 million in MA premiums and $223 million in Direct Contracting revenue, referring to its participation as a Direct Contracting Entity serving the CMS Innovation Center's Global and Professional Direct Contracting Model, effective April 1. Clover said it served 61,818 Direct Contracting lives and 67,281 MA enrollees for a total of 129,100 lives as of Sept. 30. While Direct Contracting enrollment is expected to remain relatively flat for 2021, the company said it expects those lives to "grow significantly" in 2022. Clover previously had to adjust its expectations for how many aligned beneficiaries it would serve through the model. The company reported a Direct Contracting margin of 102.4%, down from 111.8% in the second quarter, and said it expects the model's financial performance to "improve as a result of a full ramp-up in a number of areas."

Meanwhile, Orange, Calif.-based Alignment Healthcare on Nov. 4 recorded a net loss of $45.8 million, compared with net income of $10.8 million in the prior-year quarter. Overall revenue, meanwhile, climbed 18% to $293.5 million, including health plan premium revenue growth of 14% to $278.8 million. Alignment reported serving 86,000 MA members — an increase of 29% from the prior year — as of Sept. 30.

our continued growth in Medicare Advantage," he told analysts. "Our brand promise to deliver human care resonates with seniors given our comprehensive set of offerings and focus on providing a patient-centric experience based on their specific needs."

Aetna/CVS Health Raises 2021 Outlook

Finally, ***CVS Health Corp.*** on Nov. 3 reported consolidated revenue growth of 10% to $73.8 billion, while revenue in its Health Care Benefits segment reached nearly $20.5 billion, up 9.5% from the prior-year quarter. Adjusted operating income for the segment, which houses the Aetna insurance business, rose 2.4% from the prior year driven in part by strong performance in government services, despite higher costs related to COVID-19, net of deferred care, primarily in Aetna's commercial book of business, explained President and CEO Karen Lynch during a Nov. 3 earnings call.

The segment's MLR of 85.8% — up from 84.0% in the third quarter of 2020 — exceeded the company's expectations and was also driven by COVID-related costs, primarily in the commercial business. Year-to-date MA membership has climbed 9.2%, and the company is expecting double-digit growth in individual MA, with strong momentum in dual eligibles, said Lynch. The company reported serving 2.95 million MA enrollees as of Sept. 30, compared with 2.69 million a year ago.

"With the surge in nationwide COVID cases emanating from the Delta variant, we experienced higher-than-expected COVID-related medical costs in August and September," CFO Shawn Guertin explained during the call. COVID inpatient admissions in August and September were in line with peak levels seen in January 2021, and COVID testing costs also approached January 2021 levels, representing approximately 35% of gross COVID costs in the quarter, he estimated. And while non-COVID deferred care was better than anticipated, it wasn't enough to offset the higher COVID costs on the commercial side. In Aetna's government business, however, the increase in COVID treatment and testing costs was "far less pronounced" but "fully offset by better-than-expected deferred care," he added.

For the full year, Aetna is projecting MLR of 84.4% to 85.6%, an increase of 30 basis points from prior guidance, on the assumption that higher-than-expected commercial COVID costs will continue. Nevertheless, CVS Health lifted its EPS guidance for the year by 20 cents to between $7.90 and $8.00.

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MVP Health Care Taps Into 'Underserved' Market With D-SNP

Schenectady, N.Y.-based MVP Health Care has long served Medicare beneficiaries in New York and Vermont with Medicare Advantage and Medicare Savings Account plans. It is also a contractor for the New York State Medicaid program, caters to employers, and offers individual and family plans on and off the Affordable Care Act exchanges. For 2022, the not-for-profit insurer is launching a Dual Eligible Special Needs Plan (D-SNP) through a joint venture with Belong Health, a new company that was co-founded by former Cigna Corp. executive J. Patrick Foley and specializes in helping regional payers launch MA and SNP products.

The MVP DualAccess HMO D-SNP will initially be available in 13 counties, largely in the New York Capital Region and Mid-Hudson Valley, where MVP has significant managed Medicaid enrollment. The insurer estimates that more than 135,000 people in the Capital Region, Hudson Valley and the North Country are eligible for a D-SNP today. AIS Health spoke with MVP Vice President of Strategic Provider Engagement and Care Management Augusta "Gus" Martin about why entering the growing D-SNP market is a logical next step for the company. Editor's Note: The following interview has been edited for length and clarity.

AIS Health: Why was this the right time to add a D-SNP to MVP's portfolio?

Martin: MVP has a very a long history in the Medicare Advantage space, where we have enjoyed high quality scores [and] high patient loyalty and offer largely throughout our entire footprint in both New York and Vermont. This is our first foray into the integrated [Medicare-Medicaid] product line and strategically, there are a couple reasons why. One is, being a mission-driven organization, the ability to support underserved populations in the communities that we operate in was very important to us, just as an extension of our offerings and product profile…our MA strengths and our state programs. MVP has over 200,000 members in our state programs: managed Medicaid, HARP [Health and Recovery Plans serving adults with significant behavioral health needs], Child Health Plus, and the Essential plan, an off-exchange plan that falls

kind of in between Medicaid and the exchange-subsidized poverty levels.

AIS Health: How does MVP define underserved and how will the new plan break down the traditional silos of care that occur outside of integrated products?

Martin: What that means to MVP is largely folks who fall into Medicaid and/or HARP and generally have a greater degree of care needs — and many of them have a greater degree of socioeconomic challenges — and are beginning to age out [of our Medicaid programs]. Upstate New York tends to have a slightly higher average age-in population, so from a demographic perspective as well as from the strength of our state program, it seemed logical for us to not have those underserved folks in the state program aging off and going elsewhere. Another term would be "vulnerable population" who can benefit from added support in terms of their care needs and their needs beyond traditional care. These are people with multiple chronic conditions, multiple social determinants of health challenges (e.g., housing issues, food insecurity issues, lack of social support or family support), so there is a lot of complexity that comes into the Dual SNP plans, which gets into why we're partnering with Belong.

AIS Health: Why did you choose to partner with an outside firm, and what does Belong bring to the table?

Martin: In addition to the tremendous experience in Medicare and Medicaid and the regional relationships that we bring, where we felt Belong was adding [value] was an even more far reaching and more expanded experience in a Dual SNP program. They're an organization that has leadership and staff that come from tremendous backgrounds working with dual product offerings, and they created an interdisciplinary care team that really allows members to coordinate and maximize the [Medicare and Medicaid] benefit. They've helped us establish what you could call a "pod model." Each member has a dedicated team that's helping to support their care plan and engagement working both within the benefit structure — coordinating things like covered transportation for members or chronic condition meal delivery — with what's available from the locally based organizations that provide those types of services.

AIS Health: In what aspects of the plan does Belong share?

Martin: I can't get into the financial structure, but I can tell you we have a services agreement, where they've been providing a significant amount of consulting and collaboration around the building of the product and making sure it's seamlessly and fully integrated, and then supporting around the model of care, which is more than just the clinical care program and can be anything from the network build to requirements for multilingual communications. There are a number of strict and distinct [D-SNP] requirements, and they have been a great partner in assisting with all of those things, and I think will continue to be, mostly likely over time, as we grow the product and go more into upstate New York. And it is an MVP-branded product; it's on our license, it's not a co-branded offering.

AIS Health: Does this involve the hiring of additional care managers or other staff?

Martin: There is some additional hiring of what we're calling community service care coordinators. They are usually the initial touchpoint for members in helping to establish their care plan upon enrollment, and then depending on complexity, their team consists of a nurse care manager and then generally a social worker, and they work cohesively to support the care of members. So some of the staff exists today and then there is some augmenting of our staff, but the community service coordinator is probably our biggest addition in terms of staffing.

AIS Health: What types of competitors are you up against, and how will you differentiate your product?

Martin: There are several competitors, definitely some of the nationals — United, Humana — many of them have grown or started out of downstate, largely [New York City], and [regional payers like Empire BlueCross BlueShield]. In New York State, in light of the increase in age-ins, the rates of chronic conditions and, sometimes in upstate, economic challenges, this product line is one that I think a lot of carriers and health plans are looking at as an additional growth area and as a need for the community, so we anticipate that there will be some significant competition over time.

Being a regional health plan can be a disadvantage [when you're] up against large nationals, but there are a lot of times when that regional intimacy and regional relationship and boots on the ground locally, which we have throughout our entire footprint, is a key part to differentiating with this population. You need to understand within a different county who are the people seeking care, who are the community-based organizations and social support services that are supporting these members, where are they going for their food, or lack thereof, what are the housing options….I think having that ability and knowing the markets that we're in and having folks on the

ground supporting these members face to face is a big opportunity for us, and the nationals just aren't equipped to roll out plans like this across the country and then staff in each region the way we can.

AIS Health: Do you have any targets for enrollment?

Martin: The second part of the year depends on additional approvals from the state [to include the newly formed Medicaid Advantage Plus (MAP) line of business, referring to New York State's transition from its previous managed long-term care program], but for the first quarter of the D-SNP launch, we are targeting about 1,000 people. That is probably relatively aggressive, but we think [it] is attainable, and it's an ongoing enrollment process; it continues monthly as people age in or become eligible.

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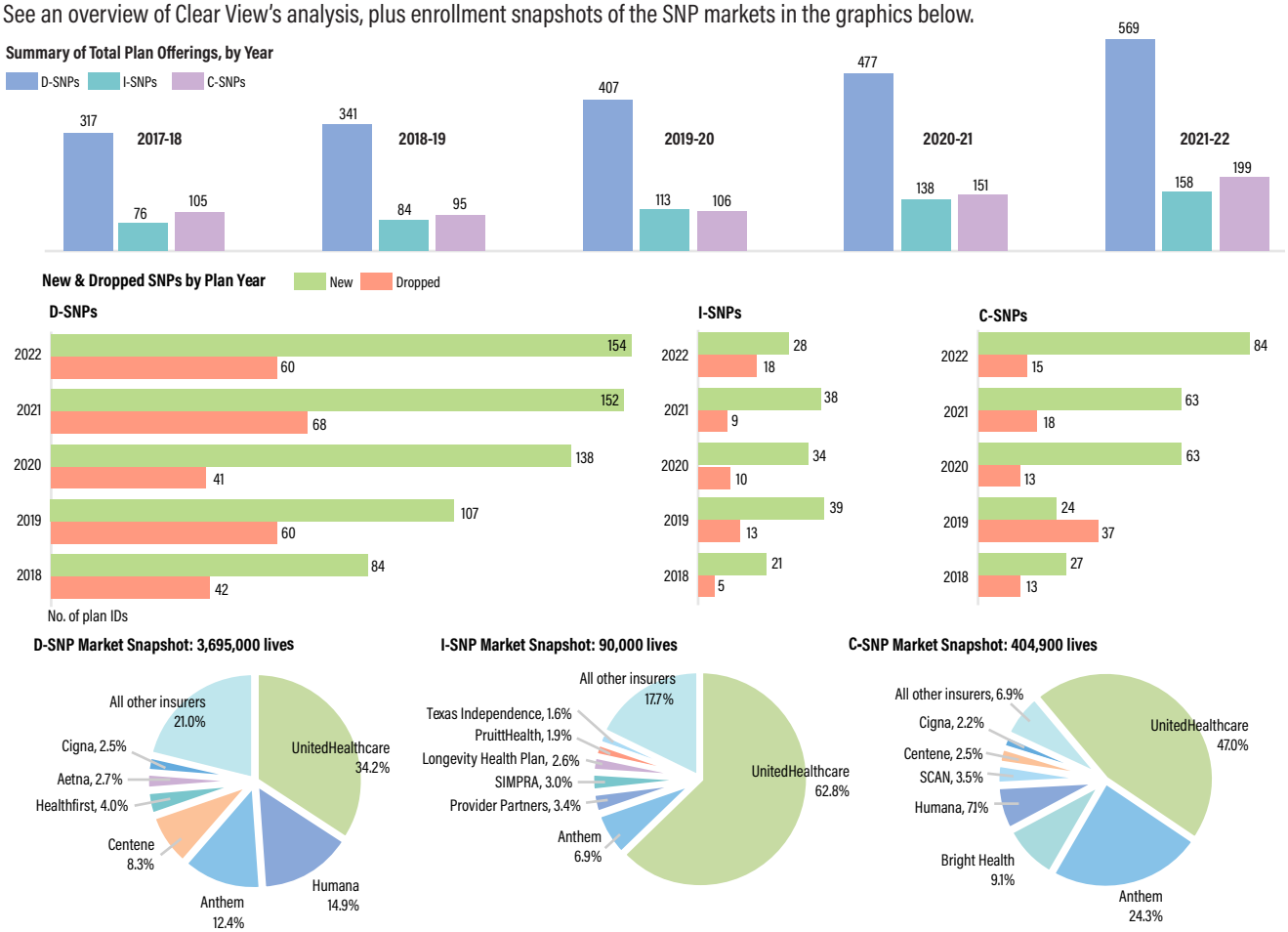
Payers Are Increasingly Attracted to Growing SNP Market

by Carina Belles

From 2017 to 2021, the number of people enrolled in Special Needs Plans (SNPs) grew 69.2%, topping 4.1 million lives, according to the latest update to AIS's Directory of Health Plans. D-SNPs saw the most growth, a whopping 79.3% increase to 3.7 million lives, followed by I-SNPs (+31.9%), then C-SNPs (+16.6%). Meanwhile, payers have grown to meet that surge, with the total number of SNP offerings expanding from 498 to 926 plans in the same time period, per an analysis of CMS's Landscape files from Clear View Solutions, LLC. Clear View's data shows that with the exception of the C-SNP market in 2019, the number of new SNP offerings has exceeded the number of plans dropped each year. And while UnitedHealthcare dominates the entire SNP market, enrolling at least one-third of members in all three segments, some local payers have also made their mark, including New York City-based Healthfirst (147,000 D-SNP lives) and Southern California's SCAN Health Plan (14,000 C-SNP lives). See an overview of Clear View's analysis, plus enrollment snapshots of the SNP markets in the graphics below.



SOURCES: DHP, AIS's Directory of Health Plans; Clear View Solutions, LLC.

More C-SNPs, D-SNPs Enter Market

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"I think, compared to pre-2018, what we're seeing is the momentum of the flywheel of permanency," says Phillips. At the same time, the BBA provided an outline for advancing integration of Medicare and Medicaid benefits for dual eligibles, although states have pursued different approaches. According to Phillips, once Indiana and North Carolina include D-SNPs under their State Medicaid Agency Contract (SMAC) in 2023, only five states will be left that do not have D-SNPs serving their dual eligibles. Per the BBA, all D-SNPs must have executed contracts with state Medicaid agencies through a SMAC that meets certain requirements. For some, this means having unified appeals and grievance processes.

Other factors contributing to D-SNP expansion include the elimination of D-SNP "look-alike" plans and the addition of Special Supplemental Benefits for the Chronically Ill, which MA plans can offer on a targeted basis in their general population but may be easier to tailor to beneficiaries in a D-SNP or a Chronic Condition SNP (C-SNP), suggests Phillips.

Look-Alikes Were Not Deterred by Changes

Regarding D-SNP look-alike plans — MA plans that are marketed to duals but are not D-SNPs or integrated products — CMS in May notified MA organizations that they would be able to transition look-alike plan membership through one of two approaches for 2022. One option was to "crosswalk" members into another MA plan (including a D-SNP for qualifying individuals) offered by the same MAO. "In subsequent years, they're not going to allow that anymore, so plans are highly motivated to start the D-SNP and become integrated with the states," which would explain some of the increase in D-SNP offerings for 2022, observes Stephen Wood, co-founder and partner at Clear View.

A handful of firms appear to be driving the growth in D-SNPs. Of the 154 new plans being offered in 2022, more than half are being sponsored by major insurers such as UnitedHealthcare (25), Centene Corp. subsidiary WellCare (18), Humana Inc. (17), Aetna (15) and Anthem, Inc. (10).

D-SNP Changes Reflect Market Repositioning

Meanwhile, 60 plans dropped out of the SNP market, but that's largely due to consolidation, points out Kirk Twiss, co-founder and partner at Clear View. For example, after Centene acquired WellCare in 2020, it phased out some of the WellCare D-SNPs where there was likely overlap. And while Amerigroup eliminated 10 D-SNPs, parent company Anthem added 10, so these instances are more likely examples of market positioning rather than loss of a state Medicaid contract or low enrollment, suggests Wood. And Clear View has not heard of any MAOs losing their D-SNP agreement with a state for failing to meet integration requirements, adds Twiss. In other words, the additional coordination requirements do not appear to be a barrier to look-alike D-SNPs transitioning to actual D-SNPs.

Although growth in the C-SNP market hasn't been as dramatic as in D-SNPs, it has been consistent given that members with chronic conditions such as diabetes, end-stage renal disease and cardiovascular disorders are easy to identify and enroll, observes Phillips. SSBCI, also enabled by the CHRONIC Care Act, allow plans to target supplemental benefits in a very specific way. Unlike D-SNPs, which can enroll dually identified individuals throughout the year, the drawback is that C-SNP enrollment is limited to the AEP.

By Clear View's count, there are 199 C-SNPs carrying over from 2021, up from 151 in 2020 and 2021. Of the 69 net new plan IDs being added for 2022, UnitedHealthcare is offering the largest number (15), followed by Bright Health (12) and Anthem/Amerigroup (10).

Although the markets for both types of plans are dominated by large insurers like UnitedHealthcare and Humana, they also attract regional insurers across the country. SCAN Health Plan, which serves more than 220,000 MA and duals members in California and is expanding to Arizona and Nevada, will offer new C-SNPs targeting diabetes and heart conditions as well as a new Institutional SNP (I-SNP), the Embrace plan. Another example is MVP Health Care, which has long served MA beneficiaries in New York and Vermont and is adding a D-SNP to its portfolio (see story, p. 4).

Regional SNPs Have Community Connections

These are plans that "have their roots in serving the communities" that they're in, and "Special Needs Plans are really a natural next step for them because it allows them to target populations and integrate benefits for populations they're already serving," explains Phillips. "It is a better way for them to address, particularly with the D-SNPs, some of the social determinants of health that are not well addressed in a fragmented, general population MA plan." National insurers are similarly motivated, but they're also driven by market share, she adds.

However, there are not a lot of new entrants in the I-SNP market, which experts say might have had more

growth had it not been for the extraordinary circumstances of COVID-19.

I-SNP enrollment is at around 90,000 members, which is up by about 2% from last year but represents a 5% decline from 2019. Meanwhile, there are only 10 net new plans for 2022, compared with 29 in 2021 and 24 in 2020. But the number of I-SNP exits wasn't remarkable, with 18 plan IDs being dropped out of 158 total I-SNPs for 2021 and 2022, points out Wood.

The "triple threat" facing I-SNP sponsors in 2020 and 2021 included 1) the devastating impact of COVID-19 on nursing home residents, 2) the financial impact of COVID-19 on long-term care facilities and other provider sponsors and 3) the difficulty COVID-related lockdowns presented to enrollment, where plans had trouble even getting agents into a facility, says Phillips. "There's still some caution and there will be some financial hits for the smaller plans, but I expect that I-SNPs will rebound with their enrollment."

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News Briefs

◊ ***The Biden administration's first Medicare Advantage and Part D regulation is pending review at the Office of Management and Budget.*** The CMS final rule, titled "Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program; MOOP and Cost Sharing Limits (CMS-4190)," was received on Nov. 10. It is not economically significant, according to the posting at RegInfo.gov.

◊ ***Continuing its push against Medicare Advantage "cuts" in pending budget reconciliation legislation, AHIP on Nov. 8 warned that increasing the MA coding intensity factor could lead to higher premiums.*** Referring to an updated Avalere Health study, AHIP reported that adjustments to coding intensity could raise MA premiums by between $9 and $25 per month, or an increase of 43% to 115%. That report also included a map showing state-by-state reductions in the availability of $0 premium plans, AHIP said. Citing an analysis performed by Wakely Consulting Group, AHIP in August cautioned that adding dental, vision and hearing benefits without adjusting the MA benchmark payment to MA plans would result in rebate reductions of 48% to 73% on average. The latest version of the $1.75 trillion Build Back Better Act (H.R. 5376), which the House is planning to vote on this week, includes only the addition of hearing benefits in 2023. The Congressional Budget Office is expected to release its full cost estimate on the bill by Nov. 19.

◊ ***Medicare Part B premiums will jump by $21.60 next year, driven in part by Biogen Inc.'s costly Alzheimer's treatment, Aduhelm (aducanumab-avwa), which was approved on June 7.*** In a fact sheet on Parts A & B premiums and deductibles for 2022, CMS said the standard monthly premium for Part B enrollees will rise from $148.50 in 2021 to $170.10 for 2022, while the annual deductible for all Part B beneficiaries will increase from $203 this year to $233. The agency explained that those increases are due to several factors, including "contingency reserves due to the uncertainty regarding the potential use" of Aduhelm. CMS has yet to complete its National Coverage Determination process to decide whether and how it will cover Aduhelm and similar drugs approved to treat Alzheimer's disease.

◊ ***Zing Health closed its previously announced purchase of Lasso Healthcare Insurance Co., which offers Medicare Medical Savings Accounts in 34 states and Washington, D.C.*** Zing Health, a Chicago-based provider of Medicare Advantage plans, and Lasso Healthcare will operate separately, while the acquisition will provide Zing with a national footprint to reach diverse communities, the insurer said on Nov. 9.

◊ ***Anthem, Inc. has entered into an agreement to acquire Integra Managed Care, a managed long-term care plan in New York that helps adults with long-term care needs and disabilities live at home.*** Integra currently serves 40,000 Medicaid members through a dedicated care management team that includes a registered nurse, social worker and coordinator, according to Anthem. The company said the acquisition aligns with Anthem's goal of growing its Medicaid business in a comprehensive and coordinated way. Financial terms of the deal were not disclosed. The acquisition is expected to close by the end of the second quarter of 2022, when Integra will join Anthem's Government Business Division.