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

Health Plan Weekly

Nov. 5, 2018
VOLUME 28 | NUMBER 44

Senior Reporters
Judy Packer-Tursman
jptursman@aishealth.com
Leslie Small
lsmall@aishealth.com
Executive Editor
Jill Brown

Best Case Scenario Is Keeping Exchange Enrollment at '18 Level

Similar to a year ago, the open enrollment period for Affordable Care Act exchange plans began Nov. 1 surrounded by political "noise." And, for the second consecutive year, slashed federal funding for ACA exchange advertising and navigator consumer-assistance programs is making it tougher to get the word out on coverage options. Year over year, there are contrasts, too, but industry experts tell AIS Health they don't see any factors that are likely to significantly boost or reduce the current national exchange enrollment figure of nearly 12 million.

Last fall insurers had to push past bad publicity about plan exits and an unstable marketplace amid Republican lawmakers' efforts to repeal and replace the ACA. Carriers were handed a shorter timeline on federally facilitated exchanges to try to sell their products, and offerings generally had higher premiums because of uncertainty over federal cost-sharing reduction (CSR) payments.

Now premiums are generally flat or declining and the marketplace seems calmer, leading some carriers to enter or re-enter markets or add products for 2019. But this time around, new Trump administration rules are forcing qualified health plans (QHPs) on exchanges to compete against short-term plans and other non-ACA-compliant options that navigators must promote to get federal dollars *(HPW 7/16/18, p. 4)*. Moreover, the individual mandate penalty is being eliminated for 2019, and political rhetoric, heating up before the Nov. 6 midterm elections, is creating confusion about what it all means — and thrusting formerly esoteric insurance terms such as "pre-existing conditions" into the public spotlight.

continued on p. 5

Amid 3Q Results, Insurers Discuss Medicare, Exchanges, Tech

With its third-quarter financial results, Molina Healthcare, Inc. continued to showcase a redemption story that contrasted significantly from the situation in 2017, when it experienced multimillion-dollar losses and ousted its two top executives.

Molina's adjusted earnings per share of $2.97 handily beat Wall Street's consensus estimate of $1.67, leading Leerink analyst Ana Gupte to conclude in a note to investors that the company "delivered another blow-out quarter."

The company also increased its 2018 earnings outlook to $9.05 to $9.25, up from a range of $7.39 to $7.59.

On a Nov. 1 earnings call with investors and analysts, Molina CEO Joseph Zubretsky attributed the company's results to actions such as re-contracting with high-cost providers in its networks, beefing up its utilization management capabilities and improving its claims payment integrity processes.

Further, the insurer sold two of its non-core assets in recent months: home-care provider Pathways Health and Community Support, LLC and its Medicaid management information systems business, Molina Medicaid Solutions. In response to

Published by AIS Health, Washington, DC. An independent publication not affiliated with insurers, vendors, manufacturers or associations.

an analyst question, Zubretsky said the company has no plans to sell any further assets.

Molina, does, however, have its eyes on growth — including in its individual book of business, which has stabilized after "years of corrective pricing actions and instability," Zubretsky said.

Thus, he noted that Molina will sell Affordable Care Act marketplace plans in nine states in 2019, including two states — Wisconsin and Utah — that it exited in 2018. In addition, the insurer will consider expanding its marketplace footprint "to be everywhere we're in Medicaid in 2020," which includes South Carolina, Illinois and New York, Zubretsky said.

Anthem Touts Tech Investments

Anthem, Inc. reported an adjusted net income of $3.81 per share in the third quarter, up 44% year over year and beating the Wall Street consensus estimate of $3.70. The company also raised its full-year earnings outlook to $15.60 per share, up from $15.40 per share.

During Anthem's earnings call, CEO Gail Boudreaux highlighted Anthem's various technology investments. Since the first-quarter launch of its new digital consumer engagement platform, Anthem Engage, the insurer has doubled the number of members using it, she said. She also noted that Anthem is building a team to leverage artificial intelligence (AI) capabilities that can help its clients more quickly identify individuals with complex conditions. To that end, CNBC reported on Oct. 24 that Anthem hired Udi Manber, who ran engineering for Google's core search products, to be its chief AI officer.

It was not all rosy news, however. Boudreaux said Anthem was "disappointed" with the MA star ratings that CMS recently announced. The insurer will have just one 5-star MA contract for the 2020 payment year, compared to three in 2019 *(HPW 10/15/18, p. 1)*. To improve, Anthem is deploying incremental capital to drive better performance on clinical quality, medication management and member experience measures. Anthem also reported higher medical costs in its Medicaid business. However, in response to analysts' questions about that result, Boudreaux noted that it's typical to have an "out-of-period adjustment" in Medicaid.

Cigna Notes Growing Medicare Focus

Cigna Corp. on Nov. 1 reported third-quarter revenues of $11.5 billion, a 9% year-over-year increase that the company attributed primarily to continued growth in its global health care (commercial and government businesses) and supplemental benefits segments. For the quarter ended Sept. 30, shareholders' net income was $772 million, or $3.14 per share, up from $560 million, or $2.21 per share, for third quarter 2017.

As of Sept. 30, Cigna had nearly 16.3 million medical customers, mostly from commercial plans, up from 15.8 million a year ago. Given Cigna's strong focus on the organic growth of its commercial plans, only 485,000 of its total membership are currently in government plans.

But Cigna President and CEO David Cordani, during the earnings call, said his company anticipates growth in Medicare Advantage, stressing its "tremendous focus in the MA business." He cited Cigna's strong performance on clinical care and customer satisfaction in CMS's Medicare quality star ratings and its "deep relationships" with clinical professionals.

Cordani also emphasized that Cigna has "made good progress" in its work to combine with PBM Express Scripts Holding Co., and said the acquisition is on track to close by year's end — with the Dept. of Justice clearing the deal in September, 23 state approvals and six state approvals pending. He conceded that the marketplace "will always be in a wait-and-see mode," but added that Cigna's customers are "optimistic they'll see a further step up of the trends they see today."

Health Plan Weekly (ISSN: 2576-4365) is published 52 times a year by AIS Health, 2101 L Street, NW, Suite 400, Washington, D.C. 20037, 800-521-4323, www.AISHealth.com.

Subscriptions to ***HPW*** include free electronic delivery in addition to the print copy, and access to all content online at www.AISHealth.com. To renew your annual subscription, please order online at www.AISHealth.com. For subscriptions for five or more users, contact sales@aishealth.com.

Senior Reporters, Judy Packer-Tursman, Leslie Small; Executive Editor, Jill Brown

Aetna Beats Expectations

Aetna Inc., which is on the precipice of being acquired by CVS Health Corp., reported third-quarter adjusted earnings of $2.96 per share, beating the Wall Street consensus of $2.83. The insurer said those results reflected a $130 million pre-tax impact from "an unfavorable provider arbitration ruling" related to Aetna's exited individual public health insurance exchange products.

That unfavorable ruling — which concerned the Hospital Corporation of America, according to Credit Suisse analyst A.J. Rice — also led to a year-over-year increase in Aetna's third-quarter commercial medical loss ratio (MLR). However, a better-than-expected government MLR "more than offset" Aetna's worse-than-expected commercial MLR, Rice wrote in a note to investors.

The insurer reported revenues of $15.3 billion for the quarter, up from $14.3 billion for the same period in 2017. Aetna attributed the increase in part to membership growth in its Medicare products. Indeed, "we estimate [Aetna] is covering 7.5M more seniors with [its] MA product in '19," Jeffries analyst David Windley wrote in a research note.

Aetna did not hold an earnings call due to its pending deal with CVS.

WellCare Discusses Acquisitions

For the third quarter, WellCare Health Plans, Inc. reported an adjusted net income of $161.2 million, or $3.33 per share, beating the consensus estimate of $3.09.

The company saw its MLR decline in all three business segments — Medicaid, Medicare and Medicare Prescription Drug Plans — but especially so in its PDP business, where its MLR dropped from 70.7% to 63.1% year over year. WellCare also revised its full-year adjusted guidance to a range of $10.90 to $11 per share, up from its previous guidance range of $10.70 to $10.90 per share.

During the insurer's Oct. 30 earnings call, CEO Kenneth Burdick noted that following the closing of WellCare's purchase of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc. and MeridianRx in September, "our integration efforts are well under way and on track."

Burdick also said the insurer's pending purchase of Aetna's PDP assets — a deal that will pave the way for Aetna to be acquired by CVS — is an "exciting transaction" for WellCare that will help it improve the pharmacy cost structure across its book of business.

View Molina's earnings report at https://bit.ly/2AFGSkA, Anthem's at https://bit.ly/2PDfBYo, Cigna's at https://bit.ly/2Py8v77, Aetna's at https://aet.na/2Rs2JRP, WellCare's at https://bit.ly/2Ojjugj. ✧

by Leslie Small and Judy Packer-Tursman

New HRA Rule Could Alter Individual, Group Markets

On Oct. 23, the Trump administration issued a proposed rule will expand the use of employer-funded health reimbursement arrangements (HRAs). Industry experts tell AIS Health that if employers opt to take advantage of the new regulation, it could add more individuals the Affordable Care Act exchanges — even if those individuals are costlier to insure.

The new proposed rule on HRAs would reverse an Obama-era policy that prohibits employers from using such accounts to reimburse their employees for the cost of individual health insurance coverage. It would also allow companies that offer traditional employer-sponsored plans to offer an HRA of up to $1,800 per year to reimburse employees for "certain qualified medical expenses," including premiums for STLD plans.

The proposed rule will fulfill the third and final prong of an executive order issued last October by President Donald Trump. His administration has already finalized rules addressing the other two aspects of the executive order: expanding the use of short-term, limited-duration (STLD) insurance plans and association health plans.

Employers Don't Want to 'Rock the Boat'

Once the new HRA rule is finalized, employers may not be in a rush to incorporate into their benefit offerings, according to Paul Fronstin, director of the Health Research and Education Program at the Employee Benefit Research Institute.

"In today's climate, with very low unemployment, employers are not looking to rock the boat," he says. "They're not going to make any kind of major change that's going to potentially look like a takeaway of compensation."

"However, when we have a recession and unemployment hits 10% again, then this may become a very attractive option," Fronstin continued. "It gives employers what they've been talking about doing for many, many years, which is providing a fixed-contribution or a defined contribution and letting workers decide what health insurance they want."

Should that come to pass, employers will have a whole host of questions to consider, such as whether the coverage offerings in the Affordable Care Act marketplaces are adequate, or whether they should adjust their HRA contribution over time, he says.

Adding another wrinkle to the equation, in 2016 Congress authorized a new arrangement called the qualified small-employer HRA, attorney Katie Keith wrote in a *Health Affairs* blog post on the new HRA rule. That allows small companies to pay or reimburse employees for premiums for minimum essential coverage — including coverage from the individual market.

For employers that want to go the qualified small-employer HRA route, the biggest advantage is that employees covered under that option could still access premium tax credits in the ACA exchanges, says Jason Karcher, an actuary in the Milwaukee office of Milliman, Inc. With the new proposed HRA rule, though, "that's not there, and in fact if your employees take your HRA, then they can't get a premium subsidy even if they're eligible for it otherwise," he adds.

Rule Raises Adverse-Selection Question

Another key question that the proposed rule raises is whether employers will opt to move only their older, sicker employees to the individual market so that they no longer bear the risk for their health expenses. To address those concerns, the regulation contains provisions that the administration says will "mitigate the risk that health-based discrimination could increase adverse selection in the individual market."

For example, if an employer offers an HRA that is integrated with individual health insurance coverage to one class of employees — such as part-time workers — it would be required to do so on the same terms for all employees within that class, Keith's post explained. "This means that an employer could not make employee-specific offers regarding an HRA, such as offering a more generous HRA to an employee based on his or her health status," she noted.

To Karcher, "it doesn't seem particularly likely that employers would have significant new adverse selection or dumping opportunities [with the new regulation] versus what they're able to do right now." The classes of employees that the rule defines are broad enough to make it difficult for employers to "target specific individuals" with their benefit offerings, he says.

But JoAnn Volk, a research professor at the Georgetown University Center on Health Insurance Reforms, says the proposed rule might still leave some room for employers to discriminate against older and sicker workers. For example, "they point out that they did not permit salaried versus hourly [when defining different classes of employees], because that could be easily manipulated, but it seems to me that the distinction between full-time and part-time is also — and perhaps even more so — easily manipulated," she says.

Takeup May Come From High-Cost Firms

Fronstin says it's possible that instead of employers trying to cherry-pick employees to shift to the individual market, companies that have high medical costs might opt to move all their employees to that market. The companies most likely to do so could be those in the retail and hospitality industries, which typically have lower-income employees and higher turnover.

"But it's pure speculation — all it takes is one automobile company or one high-tech company, and then you've got all the other ones looking at it as well," Fronstin adds. "There tends to be a herd mentality when it comes to employers changing their benefits."

The way Karcher sees it, the most likely ramification of the new rule will be moderate enrollment growth on the ACA exchanges. After all, "you are putting an additional population that otherwise would have been covered through an employer-sponsored plan potentially into individual market coverage," he says.

How Will It Affect the ACA Risk Pool?

The impact that has on the risk pool, though, could depend upon which companies take advantage of the new flexibility.

"The employers who are most likely to see a lot of value in this are ones that have higher costs or have seen higher premium growth rates in recent years," he says. Still, enrollees in the large- and small-group markets are generally healthier than those in the individual markets, "so even if you're getting what we would call less healthy groups, it's uncertain if they would be less healthy enough to meaningfully worsen the ACA risk pool," he says.

Geography plays a role, as well, Milliman actuary Fritz Busch says. "As always, it will be state-specific, particularly where it involves small-group versus individual and the relationship between those rates," he says. For example, in states where small-group rates are much lower than individual rates, it makes less sense to move employees to the individual market.

In Busch's view, the inclusion of some group-market members in the individual market is likely to be favorable to ACA marketplaces overall. On the other hand, the newly announced guidance for Section 1332 state innovation waivers *(HPW 10/29/18, p. 1)* is likely to be unfavorable for the ACA marketplaces, as states could use the new flexibility to promote non-ACA-compliant coverage like STLD plans, he says.

Thus, the new rule "probably comes at the right time" to potentially

offset any actions states might take to reduce comprehensive coverage, he says.

Volk says it's also notable that the proposed rule lets employees use an "excepted benefit HRA" to purchase an STLD plan. That, she says, could drive up premiums for ACA-compliant plans.

Karcher, though, points out that the relatively low maximum contribution — $1,800 — might discourage uptake of that option. "That might be able to buy coverage for a healthy person," he says, but employers want to keep those healthy individuals in their own risk pool anyway.

View the press release about the new rule at https://bit.ly/2RcpGbz and Keith's post at https://bit.ly/2AFYOv7. Contact Karcher and Busch via Jeremy Engdahl-Johnson at jeremy.engdahl-johnson@milliman.com, Volk at Joann.Volk@georgetown.edu and Fronstin at fronstin@ebri.org. ✧

by Leslie Small

Sign-ups Likely to Remain Steady

continued from p. 1

Amid the ongoing challenges, Centene Corp. continues to place heavy emphasis on its exchange business as the nation's largest player in the marketplace *(HPW 10/29/18, p. 3)*. Yet ACA exchanges comprise only a small portion of the business portfolios of some other insurers, and many firms of all sizes won't go beyond dipping their toes in the water for now.

So what will happen during this sign-up season? "I think the best-case scenario is maintaining [ACA exchange] enrollment at the levels we had last year," says industry consultant Rosemarie Day, founder and president of Day Health Strategies LLC. In all likelihood, she tells AIS Health, she expects to see a decline in enrollment for federal facilitated marketplaces, "and I think the state-based exchanges will work hard to maintain what they had last year."

Day and others note that the vast majority of enrollees in exchange plans receive federal subsidies, "so most are sheltered from premium increases." But, for unsubsidized individuals, there was a big spike in exchange plan premiums last year, she says.

Yet she recalls better-than-anticipated enrollment results in fall 2017. "We did better last year overall with enrollment than the more dire predictions had suggested, and that was good news," says Day, who was founding deputy director and chief operating officer of the Massachusetts Health Connector, a state-based model for ACA exchanges. She posits that state-based exchanges outperformed federally facilitated marketplaces on sign-ups because of their strong investment in marketing and outreach. "I know a lot of them [i.e., state-based exchanges] and their level of commitment," she says.

State Exchanges Outspent Feds

The Commonwealth Fund, in an Oct. 26 report, shows the federal government is spending only 51 cents per uninsured person on advertising and 51 cents per uninsured person on navigator grants. That compares to $13.23 and $13.37 budgeted, on average, respectively, by 10 responding state-based marketplaces. The five states using HealthCare.gov averaged $6.46 per uninsured person on advertising and $8.21 per uninsured person on their navigator programs.

This year, Day notes, federal regulators are allowing the enhanced direct enrollment option for federally facilitated marketplaces, thus letting consumers and agent/brokers shop, enroll and manage changes without having to create an application on HealthCare.gov. This approach "allows an improved shopping experience" and may promote more loyalty to the member's current carrier, she says. As for product design, Day says that, "because affordability is such a concern, I think there's still support for narrow networks, at least in metro areas" with a sufficient number of providers to support them.

Plans Expand Exchange Footprints

Chris Sloan, a director at Avalere Health, is encouraged that exchange "premiums in many places are going down and enrollment is going up," in part because of the expanded presence of plans including Centene, Oscar Health and Molina Healthcare, Inc. in the marketplace. He points to Anthem Inc.'s return to Minnesota, saying, "So much is driven by plans expanding their footprints in states, increasing their presence beyond urban centers." Plus, "there haven't been notable exits" for 2019, which he describes as a big change from previous years — and increasing offering more choice and competition contributes to the slowdown in premium hikes.

"But this is still not a market with much choice and there are wide swaths of the country with only one option — and the participation in this market is still nowhere close to what it was" a few years ago, Sloan says. He says the likely impact of non-ACA-compliant short-term plans is still unclear, but he doesn't anticipate much of an enrollment shift. He posits that the people most likely to be attracted to short-term plans probably have already exited the exchange market.

Sloan adds that a change in the final rule on association health plans — requiring the plan sponsor to be a viable entity even without sponsoring an employee benefit plan — is likely to dampen enrollment in this alternative.

Overall, Sloan agrees that exchange enrollment will likely be comparable to last year, "but I wouldn't be

surprised if it goes up or down a little bit" — and exchange plans' design for 2019, generally speaking, "looks standard, with slightly higher deductibles and cost sharing."

"I don't want to overstate the stability of the [ACA exchange] market," Sloan says. "It definitely is more stable [than a year ago], but it's still a really expensive market and the coverage is not good — there are high deductibles and high cost-sharing." Moreover, he says the marketplace is "still living with the effects" of steep premium increases a year ago; and although benchmark plans' rates are down slightly year over year, this is based on last year's spike.

Still, he doesn't see a dampening effect on most enrollment."We have the people in the market that we're going to have and they're relatively insulated" from premium hikes due to subsidies, he says. But he doesn't expect much of an uptick in attracting tougher-to-reach individuals since there's "nothing to draw them in."

He also says the Trump administration has been clear that it wants to offer more options to healthier people, and "there's the potential for a parallel market, based on this administration's actions."

AHIP Sees 'Quieter Year'

Kelley Turek, executive director of commercial policy for America's Health Insurance Plans (AHIP), sees generally encouraging trends from a year ago. "Last year was 'repeal and replace' [the ACA], and this year we have new short-term plan regulations expanding flexibility," she says. "But, in general, this year has been quieter — a quieter lead-up to open enrollment."

Turek points to "a very smooth open enrollment experience" for the marketplace last year, largely without the technical glitches on websites or at call centers that occurred several years ago. "From testing and early reports, it's likely going to be the same this year, so consumers should have a very smooth process," she says, "and from a plan perspective, they'll get information from the marketplace to enroll consumers smoothly."

Given the six-week enrollment season for federally facilitated exchanges, AHIP encouragesis "encouraging consumers to go in early" to enroll in plans if they want comprehensive coverage — or to sign up for alternative plans only after they take the time to "decipher" what they offer. "There will be a lot of variety in short-term plans in terms of what they cover, so consumers need to review their options very carefully," she says.

With less federal funding to promote exchanges, "issuers have to step up," Turek says, but at this point plans know what works in specific markets. Although AHIP doesn't forecast enrollment, she adds, "We're always hopeful there will be strong enrollment and consumers will get the coverage they need."

Entities Step Up to 'Fill the Void'

A shorter enrollment period, election noise and scant federal money for exchange advertising and face-to-face consumer assistance don't add up to a best-case scenario for getting people enrolled, says Adaeze Enekwechi, Ph.D., a vice president at the health policy firm McDermott+Consulting. But non-profit organizations and states "are working hard to get people covered, trying to fill the void of the federal government apparatus as much as they can," she says.

Enekwechi describes the "damage" from the drastic cuts in federal money for exchange outreach and marketing as "front loaded." She expects the effects to be "a little more blunted this year because other entities have stepped in" to promote the exchanges.

Thus, Enekwechi, too, finds it reasonable to expect total exchange enrollment to stay around 11.8 million, similar to 2017, if people stay in plans and diligent enrollment efforts are made at the state level. But she says it's still going to be difficult to reach some people at greatest risk, who may not understand that they meet income thresholds and can get coverage through HealthCare.gov for $75 to $100 per month after subsidies.

While there's always been a place for short-term plans in the market, "they were intended to be short term," she says, "and what we see now is an effort to really muddy up the waters." If roughly 2 million healthy exchange plan members shift to non-ACA compliant alternatives, as one estimate says, "it's hard to see that as a good thing," she says. "People will purchase health plans without the coverage they need and people staying in exchange plans may have more needs…So we create these terrible imbalances in the marketplace, [and] when people find out their health insurance doesn't have what they need, it's usually not at the most convenient time and it's devastating."

Plans Have Much to Gain From Outreach

Enekwechi says exchange plans "have a lot to gain" in this enrollment season by taking the time to reach consumers and educate them if necessary. Apart from the individual mandate penalty's repeal, she says, "Everybody should be aiming to have health insurance, so plans should not be shy at selling — and there are a lot more people to cover."

Contact Day at rosemarie@ dayhealthstrategies.com, Turek at kturek@ ahip.org, Sloan at csloan@avalere.com and Enekwechi at aenekwechi@mcdermottplus.com. ✧

by Judy Packer-Tursman

News Briefs

✦ ***CMS on Oct. 31 approved Wisconsin's 1115 waiver, which will extend the state's BadgerCare Medicaid demonstration for five more years and add some new provisions to the program.*** Those include requiring certain Medicaid beneficiaries to work or complete other "community engagement" activities, requiring childless adults at certain income levels to pay premiums, and locking those individuals out of the Medicaid program for six months if they fail to pay their premiums. Wisconsin is now the fourth state — in addition to Indiana, Arkansas and New Hampshire — to get federal approval to implement work requirements in its Medicaid program. Read more at https://bit.ly/2yHRPki.

✦ ***CMS issued a proposed rule on Oct. 26 that will leverage new authorities provided by the Bipartisan Budget Act of 2018, including giving Medicare Advantage plans broader flexibility in how they pay for telehealth services for enrollees.*** Among other changes, the proposed rule would also require plans to more seamlessly integrate benefits across Medicare and Medicaid. Read more at https://go.cms.gov/2zdDjQK.

✦ ***On Oct. 30, America's Health Insurance Plans (AHIP) issued a statement taking exception to CMS's proposal to modify how it conducts Risk Adjustment Data Validation (RADV) audits for Medicare Advantage plans by no longer using a fee-for-service adjuster.*** "We are greatly concerned that the proposal reverses a long-standing position…that the adjuster is legally and actuarially required," AHIP President and CEO Matt Eyles said. "We are further concerned about significant methodological issues, which according to a recent study…would cause highly random and arbitrary results. CMS' retroactive application of this proposed rule would exacerbate these problems." Read AHIP's comments at https://bit.ly/2RqXfH7.

✦ ***Approximately 2.7 million individuals from states that haven't expanded Medicaid under the Affordable Care Act could gain coverage if their newly elected governors opt for expansion or if voters pass ballot referenda, according to an Avalere Health analysis released Oct. 30.*** It says Florida, Georgia, Kansas, Maine, South Dakota and Wisconsin are considered "toss-ups" that could seek expansion if the Democratic candidate is elected governor, subject to state legislatures' approval. Expansion in these six states would result in roughly 2.4 million individuals gaining access to Medicaid coverage, while ballot referenda in Idaho, Nebraska and Utah could add another 325,000 people to Medicaid's rolls in 2019. View the report at https://bit.ly/2Q9YhHa.

✦ ***The Health Care Transformation Task Force, a national consortium of payers, providers, purchasers and patient organizations, on Oct. 30 released what it describes as "guiding principles to help the health care industry and policymakers better integrate consumer needs and preferences into benefit design."*** Highlights include a call for payers, providers and purchasers to collaborate on high-performance networks, and to set up value-based arrangements that include explicit accountability for member experience and outcomes. Read more at https://bit.ly/2CRwqaY.

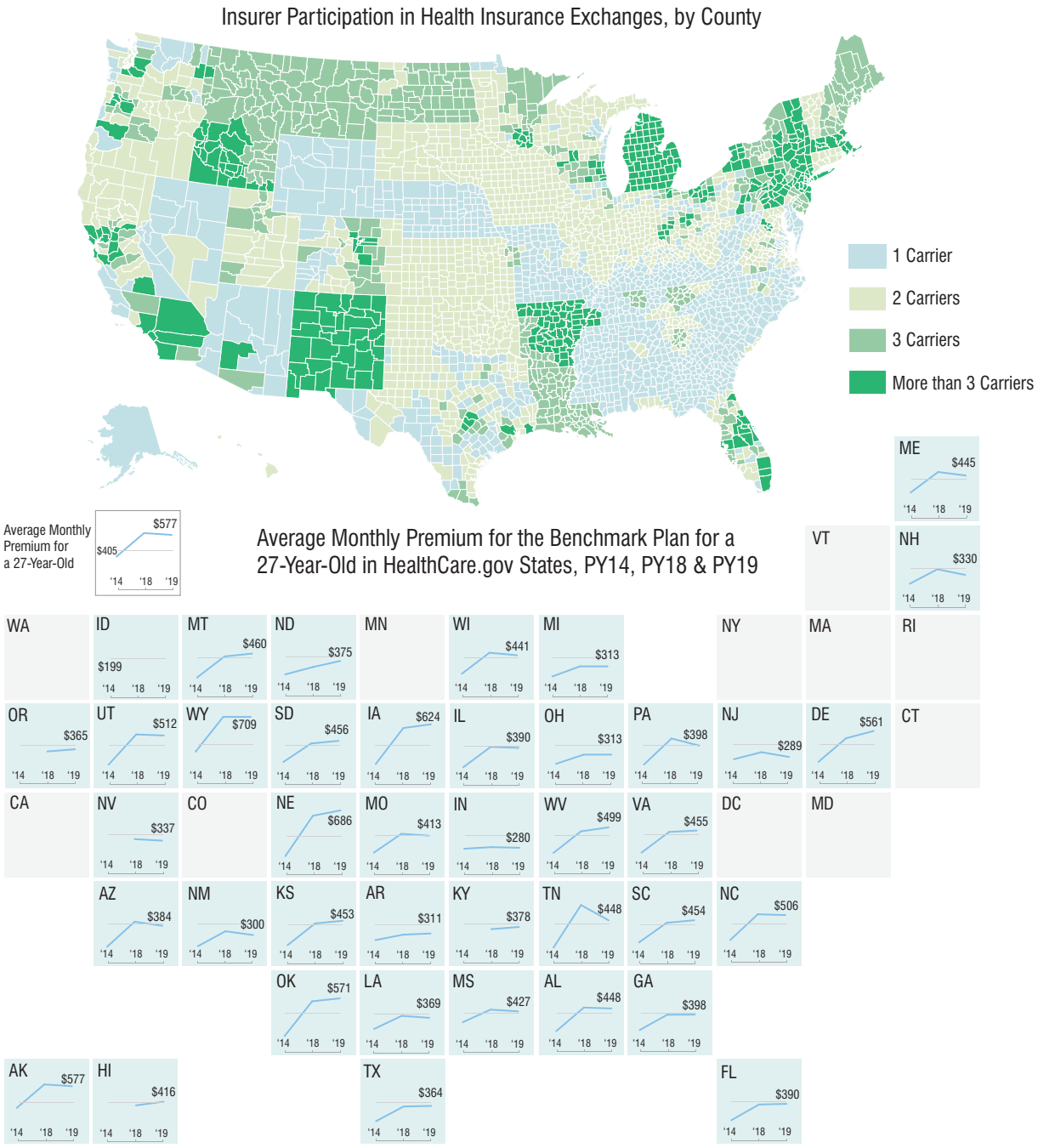
✦ ***Nationwide, the average total health benefit cost per employee climbed 3.6% in 2018, up from a 2.6% increase in 2017 and continuing to outpace inflation, according to Mercer's 2018 National Survey of Employer-Sponsored Health Plans, released Oct. 30.*** Smaller employers with 10 to 499 employees faced higher cost increases, averaging 5.4%, leading many to add high-deductible consumer-directed health plans. Prescription drugs remained the top cost driver and, among companies with 500-plus workers, overall drug benefit costs rose by about 7%. See survey highlights at https://bit.ly/2P0npUy.

✦ ***Several weeks after the Dept. of Justice approved Cigna Corp.'s $52 billion acquisition of PBM Express Scripts Holding Co., the insurer on Oct. 30 issued its latest annual study touting the value of integrated medical, behavioral and pharmacy benefits.*** For employers offering Cigna-administered benefits, the insurer found average medical cost savings of $193 annually for each covered person, and $9,792 in yearly savings for each "engaged customer" with a specialty condition, such as multiple sclerosis. Cigna also cited a 9% reduction in high-cost medical claims and a 10% reduction in out-of-network claims among customers with integrated benefits. See https://bit.ly/2Pta9Hp.

Average Monthly Benchmark Plan Premium Declines by 2% Year Over Year in HealthCare.gov States

by Jinghong Chen

CMS recently said the average monthly premium for the second-lowest cost silver plan, designated as the benchmark plan, for a 27-year-old will be $405 in PY 2019, down from $412 in PY 2018, yet 85% higher than in PY 2014. Meanwhile, more issuers participated in the exchanges in HealthCare.gov states, with 155 total state level issuers in PY 2019. Five states will have only one issuer: Alaska, Delaware, Mississippi, Nebraska and Wyoming.



SOURCE: CMS. Visit https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-2019-open-enrollment. Infographic compiled by AIS Health.

A Monthly Update for *Health Plan Weekly* Subscribers

The AIS Report on Blue Cross and Blue Shield Plans

Blues Face Challenging MA-PD Market, Gain in Star Ratings

Blue Cross and Blue Shield-affiliated Medicare Advantage (MA) plans may find it difficult to win additional members for 2019 as new national and provider-owned plans jump into markets and more people select to stick with their current insurer.

In addition, Blues and other MA plans are seeing that it's more challenging to improve in Medicare Advantage/Prescription Drug Plan (PDP) Star Ratings year-over-year, even though a larger percentage of Blues plans did become eligible for a quality bonus in 2019. Across all MA and Medicare Advantage-Prescription Drug (MA-PD) plans, star ratings decreased for standalone PDPs, while combination MA-PDs were little changed as a group, CMS data show *(HPW 10/15/18, p. 1)*.

Taken together, these factors make gaining ground in the MA market more difficult for Blues plans, says Cary Badger, principal at HealthScape Advisors, LLC, in Chicago. "We see a downward trend in switching activity," Badger tells AIS Health. "There's no reason for people to switch — rates are stable. People don't do a lot of changing in a stable market." Also, he points out, more seniors are continuing to work — and to keep their employer-provided health benefits — well beyond age 65.

continued on p. 10

New FEP Blue Focus Plan Ups Copays to Keep Cost Down

The Blue Cross and Blue Shield Federal Employee Program (FEP) is adding a new coverage option for 2019 featuring premiums that are nearly 30% lower than other FEP health plans. The new plan, called FEP Blue Focus, will be the cheapest national plan in the Federal Employees Health Benefits Program (FEHBP) for 2019.

To get prices down, FEP Blue Focus includes a narrower network and much steeper copays than FEP's Standard Option and Basic Option. As the lowest-cost national FEHBP plan, anyone whose health plan is not offered in 2019 and who does not choose an alternative will be automatically enrolled in Blue Focus.

The Blues FEP program is committed to "providing quality health insurance at an affordable price," says William Breskin, senior vice president of government programs for the Blue Cross and Blue Shield Association. Breskin says Blue Focus, with its lower premiums and skimpier benefits, should appeal particularly to "individuals just entering the workplace."

The federal Office of Personnel Management (OPM) had emphasized "innovation in benefit design" for the 2019 plan year, and its 2019 call letter, released in January, said that it wanted plans to consider making changes to their existing plans "or proposing a distinctive new plan option with value, such as modifying cost sharing for high-value and low-value benefits to help ensure members are getting the most value for their health care dollar."

In the call letter, OPM also asked plans to implement high-performance

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.

provider networks and offer reduced cost-sharing for members who use those networks, and to reduce cost-sharing when members take action to manage chronic conditions.

FEP Drops Some Premiums

Biweekly premiums for FEP Blue Focus in 2019 will be $53.14 for self only, $114.25 for self plus one and $125.67 for self and family. That's compared to Standard Option rates of $112.23 biweekly for self only, $256.54 for self plus one and $268.21 for self and family, and Basic Option premiums of $73.72 for self only, $170.57 for self plus one and $177.24 for self and family.

The Standard and Basic Option plans are lowering rates slightly for 2019, the association says.

FEP Blue Focus deductibles, total out-of-pocket expenses and some copays are higher than those in the other two plans, and the Blue Focus plan places coverage limits on several categories of expenses.

Deductibles for an individual under FEP Blue Focus are $500 per year, vs. $350 for Standard Option and $0 for Basic Option. Maximum out-of-pocket expenses also are higher: $6,500 for an individual and $13,000 for a family under FEP Blue Focus, vs. $5,000 individual/$10,000 family for Standard Option and $6,500 individual/$11,000 family for Basic Option.

Overall, copays for FEP Blue Focus generally tend to be lower for preventive services, such as primary care visits, and higher for more expensive services, such as inpatient hospital stays. For example, doctor visit copays for Blue Focus are $10 per visit for the first 10 primary and/or specialist visits, but are 30% of allowed charges for hospital and surgical services.

Unlike the Blues' Standard Option and Basic Option, FEP Blue Focus does not cover non-preferred drugs. It also does not cover out-of-network care. By contrast, Standard Option does cover out-of-network care, while Basic Option does not.

Maternity Has Higher Cost Sharing

One area where FEP Blue Focus requires additional cost-sharing compared to the other two Blues plans is in maternity care: Enrollees are required to pay a $1,500 copay for "facility care" for maternity services, compared to a $0 copay for maternity services under Standard Option and $175 for inpatient care copays under Basic Option. For 2018, the Blues association's plans dominate the FEHBP: the FEP Standard Option and Basic Option plans cover nearly two-thirds of federal employees and retirees, according to OPM.

Overall, average total premiums in the FEHBP will increase 1.3%, which according to OPM is the lowest increase since the 1996 plan year. The government contribution toward FEHBP premiums will increase by 1.2% and the enrollee share of premiums will increase on average by 1.5%, OPM says.

Federal open season begins Nov. 12 and ends Dec. 10.

Contact Breskin via association spokesperson Tess Thomson at press@bcbsa.com and OPM at (202) 606-2402. ✧

by Jane Anderson

Blues Woo Medicare Members

continued from p. 9

There are exceptions to the trends, but they won't necessarily help established Blues MA plans, Badger says. For example, markets with new entrants could see more switching activity, but potentially away from established plans. Aetna Inc. is moving into multiple new markets — 358 new counties and six new states: Idaho, Minnesota, New Hampshire, New Mexico, Oregon and Rhode Island. This competition likely will lead to fewer gains by local Blues plans in those new Aetna markets, Badger says.

The Medicare Advantage Annual Enrollment Period runs from Oct. 15 through Dec. 7.

Local Plans Pose Challenge

Renee Mezzanotte, executive vice president for client engagement at marketing firm DMW Direct in Chesterbrook, Pa., says competition heated up for 2018 with national players entering new markets. "This year, the national plans have continued an aggressive stance. But national players are not the only competition for the Blues." Provider-sponsored plans have grown in number and "have become disruptors" in MA markets where they're active, Mezzanotte tells AIS Health. "To combat this, we see Blues plans developing closer partnerships with providers to bring a best-in-class experience to their members."

For 2019, numerous MA plans — including Blues plans — are fighting for market share by adding new benefits starting Jan. 1, taking advantage of CMS easing restric-

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.

tions on MA supplemental benefits *(HPW 10/8/18, p. 1)*. The services include meal deliveries, transportation to health appointments, adult day care, caregiver support and allowances for assistive devices. Badger calls this type of innovation "the future"; Blues plans are considering the possibilities for "taking care of seniors in non-traditional settings."

Anthem Launches 'Essential Extras'

For example, Anthem, Inc., is adding a package in many markets called "Essential Extras" that includes meal deliveries, transportation, a personal home helper, assistive devices and adult day care. Blue Shield of California says it's adding a new personal emergency response system benefit that will provide help "at the push of a button."

Mezzanotte says a $0 premium is still the standard. "In fact, many Blues plans expanded their $0 premium offerings geographically, and also expanded the benefits included in their $0 plans." Blues plans also focused on their drug benefits, she says, offering $0 deductibles, expanded formularies for Tier 1 and 2 drugs and "even calling out specific pharmacies in advertising."

In addition, "attention to member experience" is helping Blues plans retain and add new members, she says, adding that the Blues' "brand" seems to matter less. "We don't hear Blues plans say, 'Members stay with us because we are Blues' as much anymore."

In 2019, plan marketing is evolving for the Blues and other MA plans, Mezzanotte says. "This year, direct mail leads consumers to customized landing pages and microsites" designed to provide "a unique journey," she says. New digital ad formats that allow more customization have allowed MA plans to better tailor their online advertising, she says.

Blues and other MA insurers also need to be mindful of new CMS Open Enrollment Period rules that allow MA members to switch plans or switch back to traditional Medicare during the first quarter, Mezzanotte says. To prevent "churn," she says, "it's critical that plans have a thoughtful communication strategy that is ready on day one for new members."

More Blues Earn 4 Stars

Although some Blues plans struggled to gain ground in the 2018 star quality ratings, overall more Blues plans earned 4 stars or above, the level that makes plans eligible for quality bonus plans. According to CMS data, 43% of rated Blues-sponsored MA-PD plans earned 4 stars or above, compared to about 37% last year and in 2016.

Only two Blues-affiliated MA-PD plans achieved 5-star ratings: Healthsun Health Plans Inc., from Anthem, and Health Options, Inc., from Guidewell Mutual Holding Company, the parent company of Florida Blue. Anthem agreed to acquire HealthSun in 2017 *(HPW 9/25/17, p. 8)*. HealthSun's plans received 5 stars for 2018.

A total of 13 Blues-associated MA-PD plans earned 4.5 stars for 2019: four Anthem plans, two from Blue Cross and Blue Shield of Massachusetts, two from Guidewell, two from Highmark Health, and individual plans offered by Hawaii Medical Service Association, HealthNow New York Inc., and Triple-S Management Corporation.

Another 17 Blues-affiliated plans received four stars, the minimum required to earn quality bonus payments. There are six from Anthem, five from Cambia Health Solutions, Inc., two from Guidewell, plus plans from Blue Cross & Blue Shield of Rhode Island, Blue Cross Blue Shield of Michigan, Blue Cross of Idaho Health Services, Inc., BlueCross BlueShield of Tennessee, and Capital Blue Cross.

'Moving From a 4 to a 5 Is Hard'

"Plans are realizing that improving star ratings is getting harder — unless you're moving from a low rating to a medium rating," Badger says. "Moving from a 4 to a 5 is hard. We didn't see too many falls in rates, but we had some plans that thought they were going to get a higher rating, and then didn't."

To improve star ratings, plans need to be strategic, focusing their efforts and resources on measures they can improve while perhaps forgoing improvement initiatives on other measures in which it may be more difficult to gain ground, Badger says.

Contact Badger at cbadger@healthscape.com, Mezzanotte at rmezzanotte@dmwdirect.com, Anthem spokesperson Hieu Nguyen at hieu.nguyen2@anthem.com, Blue Shield of California spokesperson Amanda Wardell at (415) 229-6042. ✧

by Jane Anderson

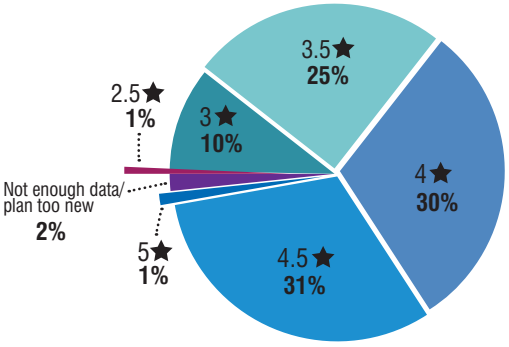
The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.

2019 Star Rating Performance for Blue Cross and Blue Shield Plans

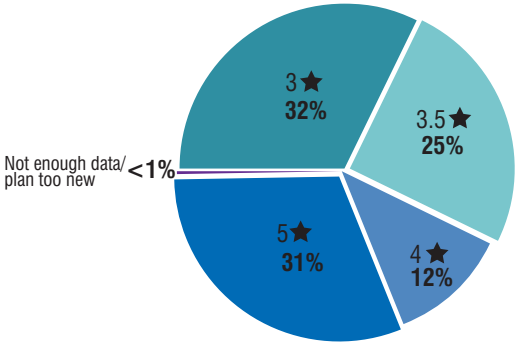
by Carina Belles

In the Medicare Advantage-Prescription Drug (MA-PD) plan market, Blues plans performed slightly worse in CMS's 2019 star ratings than their non-Blues counterparts, scoring an overall 3.90 on average, compared to 3.97 for non-Blues plans. Blues plans performed better in the stand-alone Prescription Drug Plan (PDP) space, however, scoring an average 3.95 compared to 3.13 for non-Blues entities, though Blues members make up only 6.5% of the stand-alone PDP market by enrollment.

3.4 million Blue MA-PD members

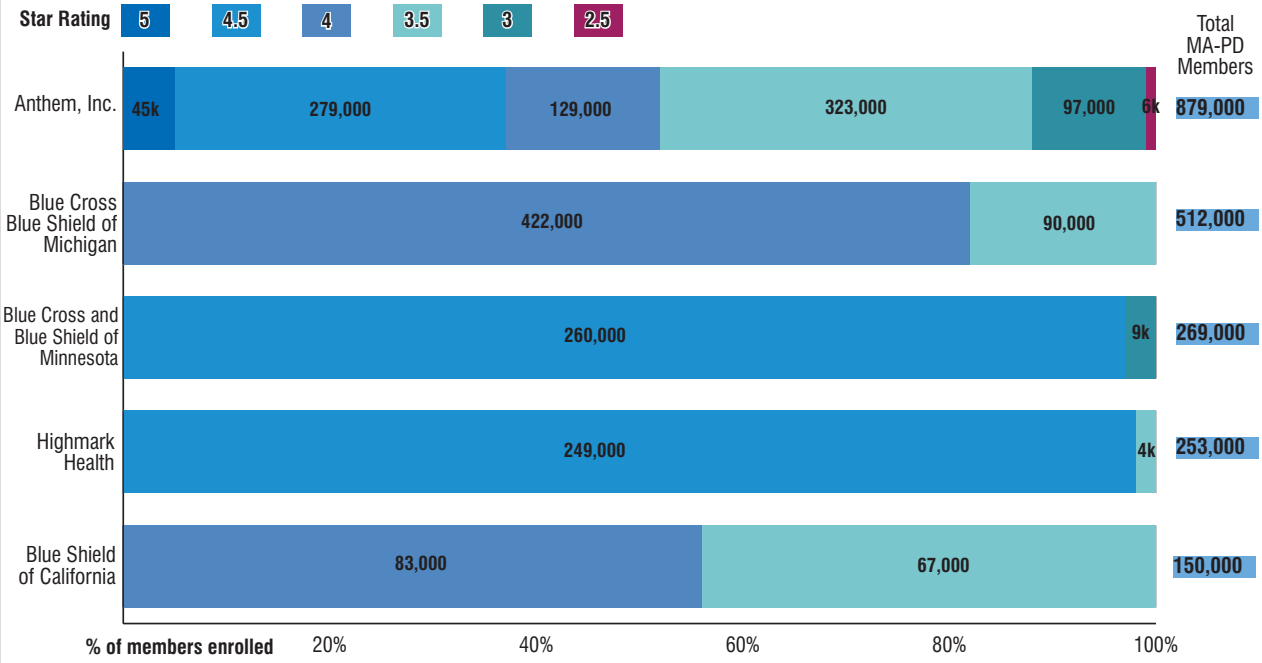


1.5 million Blue PDP members



Overall MA-PD Star Ratings Among Top Five Medicare Advantage Blues Insurers

About 17% of the national MA-PD market is served by a Blues plan, with nearly 60% of those members served by the five Blues affiliates with the largest Medicare Advantage markets. See the ratings distribution for the top five plans, as well as their current enrollment below. Market leader Anthem, Inc. was the only Blues affiliate to earn overall 5-star ratings for any of its MA-PD offerings.



SOURCE: MMM, AIS's Medicare and Medicaid Market Data; Centers for Medicare and Medicaid Services.

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.