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WellCare Acquisition Would Put Centene in a 'New Tier'

In a $17.3 billion deal that would make the country's largest Medicaid managed care organization even larger, give it a greater foothold in the Medicare Advantage (MA) market, and perhaps shield it from uncertainty surrounding the Affordable Care Act (ACA), Centene Corp. said March 27 that it agreed to purchase WellCare Health Plans, Inc.

"WellCare brings to Centene high-quality Medicare capabilities, including their strong Medicare Advantage platform, and further extends Centene's robust Medicaid offerings," Centene CEO Michael Neidorff said on a call with investors after the deal was announced. "This expertise provides a compelling growth opportunity given the country's aging demographic."

Centene has 7.7 million Medicaid members in 21 states, according to the latest update to AIS's Directory of Health Plans (see infographic, p. 8). WellCare is the fourth-largest Medicaid MCO, with 3.9 million members in 12 states. Combined, the companies will have nearly 12 million Medicaid lives.

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What Are Practical Implications of Dueling Health Care Salvos?

Health insurers, working to finalize bids by a June deadline to participate in 2020 as qualified health plans in Affordable Care Act exchanges, are once again facing uncertainty arising from an action taken by the Trump administration. Some experts view the Dept. of Justice's March 25 filing — asking the Fifth Circuit Court of Appeals to strike down the entire ACA, not just the individual mandate, pre-existing condition protections and guaranteed issue, and to affirm a Texas district court's December ruling — as more of a political fight than a legal one.

Meanwhile, House Democrats on March 26, in an apparently uncoordinated development according to one ACA observer, introduced the "Protecting Pre-Existing Conditions and Making Health Care More Affordable Act of 2019" to strengthen the ACA — by expanding the availability of subsidies to additional income brackets, making premium tax credits more generous, funding state-based reinsurance or subsidy programs, and invalidating the Trump administration's short-term health plan regulations, among numerous provisions. But the new legislation seems unlikely to move forward any time soon with the GOP-controlled Senate.

Also on March 26, several Senate Democrats introduced S. 873, The Stabilize Medicaid and CHIP Coverage Act of 2019, which would enact 12-month continuous eligibility in Medicaid and the Children's Health Insurance Program.

As a practical matter, credit rating agency A.M. Best asserts in a March 27 briefing paper that as the industry prepares for the 2020 selling season and rate filings, "the prospects of uncertainty will be disruptive" as the Trump administration's move ramps up pressure on health insurers. But other experts see the latest maneuvering

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on Capitol Hill as unlikely to shift plans off course in the short term. And they assert it would be difficult to pull the rug out from under a popular, established health care program.

Industry consultant Rosemarie Day, founder and president of Day Health Strategies LLC, tells AIS Health that plans "have to continue to do their strategic planning and look at all of these various scenarios," including outright ACA repeal, even if it's unlikely, since, as she puts it, "it's almost like the uncertainty of all of this has become the certainty."

Yet in general she thinks health plans are likely looking down the road. "My guess is that they don't think they need to worry about it for 2020 because the court case won't be decided and nothing will happen in Congress this year…but they will consider it for 2021."

"I think there's all this noise and swirl, but we are where we are for another year," says Day, formerly the founding deputy director and chief operating officer of the Massachusetts Health Connector, a state-based model for ACA exchanges.

Last year a group of Republican governors and state attorneys general turned to the courts after repeated GOP congressional efforts to "repeal and replace" the ACA failed in summer 2017. In December, a U.S. District Court judge in Texas struck down the entire ACA, asserting its mandate that individuals must buy health insurance is unconstitutional and the rest of the law can't stand without it *(HPW 12/24/18, p. 1)*. The case is now in the Fifth Circuit Court of Appeals and is seen by some observers as likely to come before the U.S. Supreme Court in 2020.

"It seems to me the significance [of the DOJ filing] is probably more political than legal," says Timothy Jost, emeritus professor at Washington and Lee University School of Law.

Jost asserts there's a strong argument that the plaintiffs lack standing, and he points to the Supreme Court's 2012 ruling upholding the ACA and ruling its requirement that most Americans get insurance or pay a financial penalty was authorized by Congress' power to levy taxes. "The mandate remains constitutional as a tax because at this point it doesn't require anyone to do anything," and is thus not invalid under the Commerce Clause, he says.

Most important, Jost says, is "even if the individual mandate is unconstitutional, that shouldn't affect any of the rest of the ACA" under so-called severability.

However, if the ACA were struck down by the courts, the effect of that would be "breathtaking," Jost says. "It would mean 20 million people would be off health care," end Medicaid expansion and consumer protections for people with pre-existing conditions and others, jeopardize the framework under which the FDA approves biosimilar drugs, and much more. So, practically speaking, "it would be a disaster for the health care system and every part of it," he says.

America's Health Insurance Plans (AHIP) issued a statement after 11 p.m. on the day of the DOJ's filing, calling it "a significant reversal" from the department's previous defense "of all of the ACA other than the individual mandate, guaranteed issue, community rating, and pre-existing condition provisions."

Centene Has Largest ACA Exposure

Credit Suisse analysts said in a March 26 note to investors that, among the firm's covered managed care organizations, Centene Corp. has the largest exposure to the ACA (both public exchanges and Medicaid expansion). MCOs with fairly limited exposure include Anthem, Inc. (Medicaid expansion and exchanges), Cigna Corp. (modest exchange exposure), and UnitedHealth Group (Medicaid expansion), they said, estimating "health insurance

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exchange and Medicaid expansion together likely contribute close to 40% of earnings" for Centene, 3% to 4% of earnings per share for Anthem, and less than 1% for Cigna and UnitedHealth. Humana "has no meaningful ACA exposure," they added, noting the district court's decision "would end all other ACA provisions such as closing the Medicare Part D donut hole, as well as the health insurer fee."

End of Medicaid Expansion May Be Costly

In A.M. Best's analysis, the firm worries that "if Medicaid expansion and/or the individual exchange programs are eliminated or changed substantially, the health insurance industry could face a loss of premium, excessive administrative overhead and financial losses."

"States may not be able to absorb the full cost of providing Medicaid coverage and may change the eligibility definition to reduce enrollment. A rollback of Medicaid expansion mainly would affect the publicly traded carriers, while changes to the individual exchange business will have a larger impact on Blue Cross Blue Shield and regional plans. If provisions such as essential health benefits, free preventive care, limits on out-of-pocket maximums and coverage for dependents up to age 26 are no longer required, commercial groups may choose to offer a lower level of benefits, thereby reducing premium levels."

But A.M. Best sees some potential upside for the health insurance industry if the ACA is eventually thrown out by the courts. "Conversely, many companies that exited the individual market after ACA implementation would be able to come back and offer policies similar to pre-ACA products, in which a policyholder decides the level of benefits needed and medical underwriting protects carriers from adverse selection," its report says. "The elimination of the Health Insurance Fee also would have a positive impact on profitability for the entire industry."

Read about the House Democrats' legislation in a *Health Affairs* blog post at https://bit.ly/2UXlM8S. Contact Day at rosemarie@dayhealthstrategies.com and Jost at jostt@wlu.edu. ✧

by Judy Packer-Tursman

New Depression Drugs Act Fast But Raise Many Payer Issues

No one seems to dispute that the first medication specifically aimed at treating postpartum depression could be a breakthrough for a debilitating condition for which there is much unmet need. But there is also consensus that the FDA's approval of Zulresso (brexanolone) injection — coming two weeks after the agency's green light on March 5 for a nasal spray for major depressive disorder in adults — could present similar payer challenges.

For starters, both Zulresso, the postpartum depression drug expected on the market this summer, and the nasal spray, Spravato (esketamine), which is now available for purchase, are costly. Zulresso's initial list price in the U.S. will be $7,450 per vial, resulting in a projected average course of therapy cost of $34,000 per patient before discounts, according to its manufacturer Sage Therapeutics, Inc. As for Spravato, the first month cost of twice-weekly treatment with the new nasal spray will range from $4,720 to $6,785, and a month of maintenance therapy will range from $2,360 to $3,540, says its manufacturer Johnson & Johnson's Janssen Pharmaceuticals, Inc.

Moreover, there will be additional costs to consider since Zulresso must be administered as a 60-hour continuous intravenous infusion, most likely in the hospital, because of the FDA's concerns about serious risks, including loss of consciousness. With Spravato, patients must self-administer the nasal spray under the supervision of a health care provider in a doctor's office or clinic certified by the drug's manufacturer since it is designated as a Schedule III controlled substance that may carry the risk of illicit use or diversion.

Federal regulators are imposing strict parameters for the use of both new products, which each have a cautionary boxed warning on their labels. The FDA approved Zulresso and Spravato with a Risk Evaluation and Mitigation Strategy (REMS), making each medication available to patients through a restricted distribution program at certified health care facilities.

Providers 'Understand the Urgency'

"Our hope is we'll have hundreds of [Spravato-certified] centers open across the country in the first year," Kristina Chang, a Janssen spokesperson tells AIS Health. Says spokesperson Alexis Smith of Sage Therapeutics: "In our discussions to date [about Zulresso], providers are willing to work with Sage to enable a pathway to care for patients because they understand the urgency" associated with treating postpartum depression.

Dea Belazi, Pharm.D., president and CEO of AscellaHealth, a Berwyn, Pa.-based PBM, sees concerns arising from the entry of two expensive new antidepressants into the U.S. market in a matter of weeks — and some parallels between the products.

"Obvious parallels are the depression illness and the use of high cost specialty medications," Belazi says. "I think if this continues there is a larger sustainability issue. Can we as a health-

care model or financial structure afford to treat largely prevalent diseases like depression, asthma or even diabetes with drugs that are tens of thousands of dollars? Probably not, and therefore access to these novel treatments will be limited."

For Spravato, its manufacturer's spokesperson Chang says that, depending on the site of administration, the medication may fall under the medical benefit, pharmacy benefit or both.

Given the "significant cost dynamic" of Spravato, payers will use due diligence, wanting pre-authorization and assurance that the patient has tried multiple traditional therapies first, Belazi says. "It's not a cakewalk. There are some challenges with [Spravato's] use." He estimates administration costs of at least $100 to $200 per session

Judge Strikes Down Medicaid Work Requirements in Kentucky, Arkansas

A federal judge on March 27 struck down programs in Kentucky and Arkansas that impose work requirements on Medicaid beneficiaries — a move that is already leading some to speculate about the impact on Medicaid managed care organizations.

U.S. District Court Judge James Boasberg's decision marked the second time that he's scuttled Kentucky's program, known as Kentucky HEALTH. He ruled last summer *(HPW 7/9/18, p. 1)* that when it approved the state's Section 1115 waiver, the Trump administration "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid."

The administration then re-approved the state's waiver request, which was met promptly with another court challenge. In his second ruling, Boasberg wrote that because the administration's reapproval "was both contrary to the [Medicaid] Act and arbitrary and capricious, the Court will vacate it and remand to HHS for further review."

In his decision in the Arkansas case, Boasberg said the same reasoning he relied on in his initial ruling against Kentucky's program can be applied. He also rejected the government's argument that Arkansas' already-implemented program shouldn't be halted due to the risk of disruption — saying the government will suffer considerably less harm than the more than 16,000 Arkansans who have lost their Medicaid coverage due to the state's work requirements.

The Kentucky ruling could have big consequences for the state's Medicaid managed care organizations, Citi analyst Ralph Giacobbe advised investors. He noted that Republican Kentucky Gov. Matt Bevin threatened to roll back Medicaid expansion in the state — which could impact 400,000 enrollees — if his Medicaid reforms do not survive legal challenges. CVS Health Corp./Aetna, Humana Inc./CareSource, WellCare Health Plans, Inc., Passport Health Plan and Anthem, Inc. all have Medicaid contracts in Kentucky.

In a statement released on Twitter after Boasberg issued his opinions, CMS Administrator Seema Verma maintained her support of Medicaid work requirements.

"We will continue to defend our efforts to give states greater flexibility to help low income Americans rise out of poverty," she wrote. "We believe, as have numerous past Administrations, that states are the laboratories of democracy and we will vigorously support their innovative, state-driven efforts to develop and test reforms that will advance the objectives of the Medicaid program."

In fact, the administration on March 15 approved Ohio's work-requirements waiver, making it the ninth state to receive the green light for such a program. Just days later, New Hampshire residents filed a lawsuit challenging the administration's approval of that state's Medicaid waiver program, which includes work requirements.

Meanwhile, Boasberg's rulings already appear to be influencing other states' Medicaid waiver plans. In Idaho, a Medicaid work-requirements bill failed in a Senate committee on March 27, according to the Associated Press. And in Iowa, key Republican lawmakers said a proposal to add work requirements to the state's Medicaid program likely won't become law this year, the *Des Moines Register* reported that same day.

View the Kentucky ruling at https://bit.ly/2JNDRFq and the Arkansas ruling at https://bit.ly/2CIp2y1.

by Leslie Small

which, at two sessions weekly, "adds up pretty quickly." Moreover, he says, payers will have to work with the psychiatric community on proper coding, assuming certified administration centers are accessible to their patients.

Belazi says the new prescription medicine for postpartum depression — which is the most common medical complication of childbirth, affecting 400,000-some women annually in the U.S. — is likely to be covered under the medical, not the pharmacy, side of the benefit. He adds that it is "hard to say if there will be a lot of uptake. There are challenges."

Hospitalization May Be Difficult for Moms

With Zulresso, it's a challenge for a new mother to be hospitalized in an approved facility for two-and-a-half days for an IV infusion, Belazi says. Moreover, he says, there is "the fact that there are possible extensive side effects and the data on its [i.e., Zulresso's] effectiveness [are] moderately better than placebo. The cost will also play a barrier."

Zulresso has limitations, says David Lassen, Pharm.D., chief clinical officer for Prime Therapeutics, a Minnesota-based PBM collectively owned by 18 Blue Cross and Blue Shield plans. "It is an alternative to treatment failures with other first line products," he says. "Because it has not been directly compared to other first line agents and has a significant safety profile (sedation, loss of consciousness with health care administration), it should be reserved for use after other standards of care have been exhausted."

Yet Camille Hoffman, M.D., associate professor in the University of Colorado's Department of Ob/Gyn, describes the newly approved postpartum depression drug as "a breakthrough medication" that "rapidly improves postpartum depression out to, at least, 30 days following the one-time treatment."

She acknowledges the need to administer Zulresso via a 60-hour IV drip and its restricted distribution might present challenges and add significantly to costs. However, she says, "I hope that payers will consider these potential barriers in light of how quickly it acts to help women with severe postpartum depression," allowing them to get "back to being able to enjoy motherhood and care for themselves and their families."

Read about the FDA's approval of Zulresso at https://bit.ly/2uhwGKR and its approval of Spravato at https://bit.ly/2EGkhF0. Contact Belazi via Matthew Singh at msingh@cpronline.com and Lassen via Denise Lecher at denise.lecher@primetherapeutics.com. ✧

by Judy Packer-Tursman

Centene Agrees to Buy WellCare

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WellCare also serves 537,000 Medicare beneficiaries, according to AIS Health data, and acquiring the company will boost Centene's MA enrollment by 180%. In addition, WellCare will become the third-largest Medicare Prescription Drug Plan insurer in the country — with 3.2 million members — once it fully integrates Aetna Inc.'s PDP business in 2020.

To Alex Shekhdar, a Medicaid managed care expert and former vice president of policy for Medicaid Health Plans of America, Centene's deal to acquire WellCare is a "Medicare Advantage/LTSS [long-term services and supports]/duals play."

WellCare has a long history in the government programs space, divided between Medicare and Medicaid, he explains. And Centene, which is dominant in the ACA marketplaces and Medicaid, has been looking to increase its MA footprint. Plus, the synergies between Centene and WellCare in the LTSS space provide for a number of opportunities, Shekhdar adds.

Deal Might Aid Dual-Eligible Integration

Thanks to the Bipartisan Budget Act of 2018, there's another good reason for Centene to bolster its Medicare presence.

"This is probably the largest manifestation of a corporate strategy dedicated toward the dual-eligible roadmap for integration," Shekhdar says. The budget act set forth a roadmap aimed at improving care integration for people dually eligible for Medicare and Medicaid, and "this helps to set that trajectory" for Centene, regardless of how states decide to pursue dual integration, he adds.

To Wall Street analysts, the tie-up makes sense — even if not all of them were expecting it.

"Overall, we believe the deal is the right strategy, giving Centene significant diversification and a much larger Medicare presence at a reasonable price," Oppenheimer's Michael Wiederhorn wrote in a research note. "The deal puts Centene into a new tier as a significant player among the diversified MCOs and solidifies its growth path for years."

"When the headlines hit last night, we were somewhat surprised given [Centene's] already hefty Medicaid coverage/footprint, its strong track record of retaining/winning RFPs [requests for proposals], and weaker currency given recent stock performance," Citi's Ralph Giacobbe wrote in a March 27 note to investors. However, Centene has "done well with recent larger deals," and WellCare does offer further scale

and an opportunity to gain more MA business, he added.

Centene's most recent major deal was its 2018 acquisition of Fidelis Care, New York's largest Medicaid insurer *(HPW 4/30/18, p. 4)*. Also last year, WellCare purchased Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., and their affiliated PBM MeridianRx, further bolstering the firm's government business *(HPW 6/4/18, p. 1)*. During his call with investors, Neidorff noted that both Centene and WellCare "have strong records of executing and successfully integrating acquisitions."

Divestitures Could Be in the Cards

Still, both Centene and industry analysts expect the deal to receive careful scrutiny — and that the combining companies will likely have to sell off some assets in areas where they have overlapping Medicaid business.

"While this deal likely has few antitrust issues, the overlap in some key Medicaid states will provide an opening for antitrust and state regulators to take a hard look at the transaction," Credit Suisse analyst A.J. Rice advised investors. Jefferies analyst David Windley wrote that he sees "potential for divestitures given high Medicaid concentration" in Illinois, Florida, Georgia and Missouri — an observation echoed by other analysts.

However, "we note that navigating through a Medicaid overlap issue is generally manageable as states can always partner with a new health plan in the next RFP cycle (or issue an RFP intra-contract cycle)," Rice added.

Neidorff acknowledged the overlap in the two companies' Medicaid business, but added that "we believe it's all very manageable." Centene said it expects the transaction to close in the first half of 2020.

As Centene is the country's largest carrier of individual marketplace plans and a major beneficiary of the ACA's Medicaid expansion, some wondered whether its move to purchase WellCare was a reaction to the continued uncertainty over the health care law's future.

That uncertainty increased when the Dept. of Justice (DOJ) sent a letter to the Fifth Circuit Court of Appeals on March 25 taking the position that the entire ACA should be invalidated because the individual mandate penalty has been zeroed out (see story, p. 1). With its letter, the DOJ fully sided with a lower court's ruling to that effect in a case brought by Republican-led states. Previously, the DOJ took the position that only certain provisions of the law should be overturned.

Shekhdar says Centene's ACA exchange exposure "could be concerning" given how dominant it is in that market — and especially in light of the DOJ's new position on the law. Thus, the move to acquire WellCare "may be a bit of a hedge" against that, he says.

CEO Is Unfazed by 'Headline Volatility'

During Centene's March 27 conference call, Neidorff responded to an analyst question about the subject with his characteristic ambivalence regarding what he deemed "headline volatility."

"We are comfortable with it — we have always maintained that you base your decisions at a point in time based on the facts as they're known today," he said, adding, "there were times when we were expanding in the marketplace [and] everybody said, 'why are you doing that now?'"

The way Neidorff sees it, "these things have a long way to play out," and he predicted that either the Fifth Circuit Court of Appeals or the Supreme Court will overturn the lower-court ruling against the ACA. That said, he did admit Centene is "doing contingency planning," though he declined to go into further detail.

To Leerink, "fears that this deal has been inked to offset secular headwinds are unfounded," Gupte advised investors. "Headline risk is part of investing in Managed Care and requires a strong investor stomach, but the fundamentals and policy setup are strong."

Factors including Medicare Part D rebate changes and the ACA lawsuit "are all par for the course in this space and may we say nothing compared to what we experienced in 2009," she added.

PBM Contract Raises Questions

To Rice, "another interesting angle" on the Centene/WellCare deal is how the companies will handle their PBM segment once combined, as WellCare's current PBM contract with CVS Health Corp. expires at the end of 2020. Centene, meanwhile, "has already given notice to CVS on moving its PBM in-house," as it is transitioning its PBM business to RxAdvance, in which it invested an unspecified amount in March 2018 *(HPW 3/19/18, p. 8)*.

Given that WellCare has said its pharmacy spending is in the $15 billion to $20 billion range, that "would significantly enhance the scale of [Centene's] new PBM business," Rice observed. For CVS, though, "the exposure to the PBM phase out is limited, in our view," Gupte advised investors.

For his part, Neidorff hinted at the two firms' overall pharmacy strategy in an environment that includes increased state pressure on PBMs as well as looming changes to the prescription drug rebate system for government plans.

"We recognize the need for value-based solutions, increased trans-

parency and efficiency across the pharmacy industry," he said. "The combined company's broad portfolio of pharmacy assets make it well positioned to drive value for our government customers."

After the close of the transaction, Neidorff is slated to lead the combined company as chairman and CEO, while WellCare CEO Ken Burdick and Chief Financial Officer and Executive Vice President Drew Asher are expected to join the Centene senior management team in newly created positions, according to a press release.

Analysts, though, suggested a different plan could materialize.

Neidorff's succession plan, Windley noted, "has been a recurring question," as his contract runs until 2021. Thus, he wrote in a subsequent research note, "we are a little surprised" Centene didn't announce that Burdick would become the new CEO.

"On the other hand, CEO Neidorff stressed the importance of [Centene's] culture and that he wanted to evaluate fit as the companies come together. Additionally, announcing new leadership before the deal closes could unnecessarily prompt executive level turnover," Windley added.

Contact Shekhdar via Joe Reblando at joe@joereblando.com. View Centene's press release at https://bit.ly/2Fr3A0I and listen to a replay of its conference call at https://bit.ly/2HYRgaU. ✧

by Leslie Small

News Briefs

✦ ***U.S. District Court Judge John Bates on March 28 ruled against the Trump administration's regulation expanding association health plans.*** The administration issued its final rule in June *(HPW 6/25/18, p. 1)*, leading attorneys general from 11 states and the District of Columbia to file suit against the administration, alleging the rule violated both the Employee Retirement Income Security Act (ERISA) and the Affordable Care Act (ACA). Bates sided with the plaintiffs in his opinion, stating that the rule was "designed to end run the requirements of the ACA" and that it "unreasonably expands the definition of 'employers' to include groups without any real commonality of interest and to bring working owners without employees within ERISA's scope despite Congress's clear intent that ERISA cover benefits arising out of employment relationships." He thus vacated two key provisions of the rule and remanded the rest of it back to HHS to consider whether any part of the regulation could still stand. View the opinion at https://bit.ly/2TIVGVz.

✦ ***Centene Corp. said on March 28 said that its subsidiary NH Healthy Families successfully reprocured its five-year Medicaid managed care contract in New Hampshire***. Centene serves 60,989 Medicaid HMO enrollees in New Hampshire, according to AIS's Directory of Health Plans. See https://bit.ly/2uvSti6.

✦ ***Researchers project that a reinsurance program with an 80% payment rate for expenditures between $40,000 and $250,000 would cost $30.1 billion from 2020-2022.*** Yet they observed considerable variation in reinsurance programs and estimated costs between the four states they examined: California, Florida, Illinois and Texas. They also projected that 631,112 enrollees would be covered by a federal reinsurance program with a $20,000 attachment point; although such a program would only cover about 3% of individual market enrollees, their health care expenditures would account for more than half of individual market health care expenditures (ie, $34.1 billion of $66.4 billion). Read the study abstract in the journal *Inquiry* at https://bit.ly/2Cx9TiH.

✦ ***In the most recent ACA open-enrollment period, 11.4 million people selected plans in the 50 states and the District of Columbia,*** CMS said March 25 in its final exchange enrollment report. That's a decline of 300,000 plan selections year over year, according to the agency. CMS also said it will allow insurers to offer "grandmothered" plans — which don't meet all the ACA's coverage requirements — for another year. Read more at https://go.cms.gov/2UVQm2H.

✦ ***CORRECTION:*** A table published in the March 25 issue of *HPW* indicated Centene Corp. experienced a major stock market loss in February. Rather, Centene announced a two-for-one split of its shares of common stock in the form of a 100% stock dividend distributed on Feb. 6, 2019. Thus, the decline was due to the number of shares issued relative to market capitalization.

Centene Bets on Medicaid Market With Proposed WellCare Acquisition

by Susan Namovicz-Peat

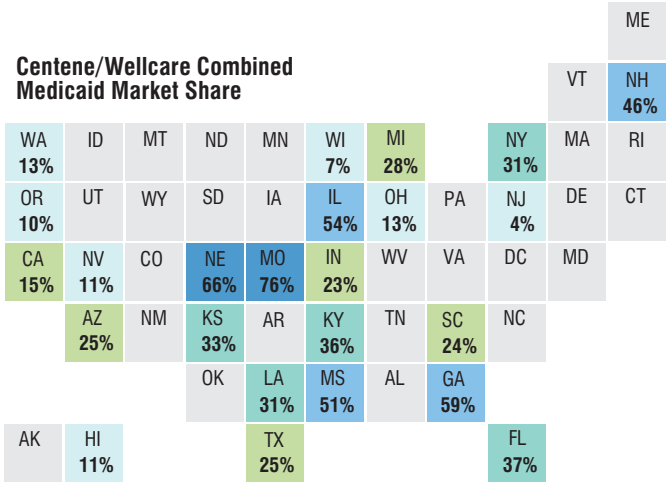
Centene Corp.'s bid to acquire WellCare Health Plans, Inc., would push it to fourth place among the large national health insurers, with a combined 17.6 million medical lives, edging out Cigna Corp. with around 16 million. Managed Medicaid makes up 54% of Centene's enrollment and 83% of WellCare's membership, and together they have Medicaid contracts in 24 states. Centene is already the leading Medicaid insurer in Louisiana, Mississippi, New York and Texas. WellCare is the largest Medicaid HMO in Florida, Georgia, Illinois, Kentucky, Michigan and Missouri, and a combined entity could assume first place in Arizona and Nebraska as well. WellCare also brings standalone PDP business to the union, as it is the fourth largest health insurer in this market. Both companies also participate on the Affordable Care Act (ACA) exchanges.

States that would experience the biggest shakeup are Arizona and Nebraska, where neither company is in first place but a combined Centene/WellCare entity would take the lead. In Arizona the new entity would leapfrog over UnitedHealthcare, Mercy Care Plan and Health Choice Management Co. In Nebraska Centene would surpass UnitedHealthcare. Regulators might take issue with the proposed deal in Nebraska, Missouri and Georgia, since any mergers in these states will leave only two or three participants in those programs. Centene would also gain a significant share of the Illinois and Florida markets, where WellCare is already dominant.

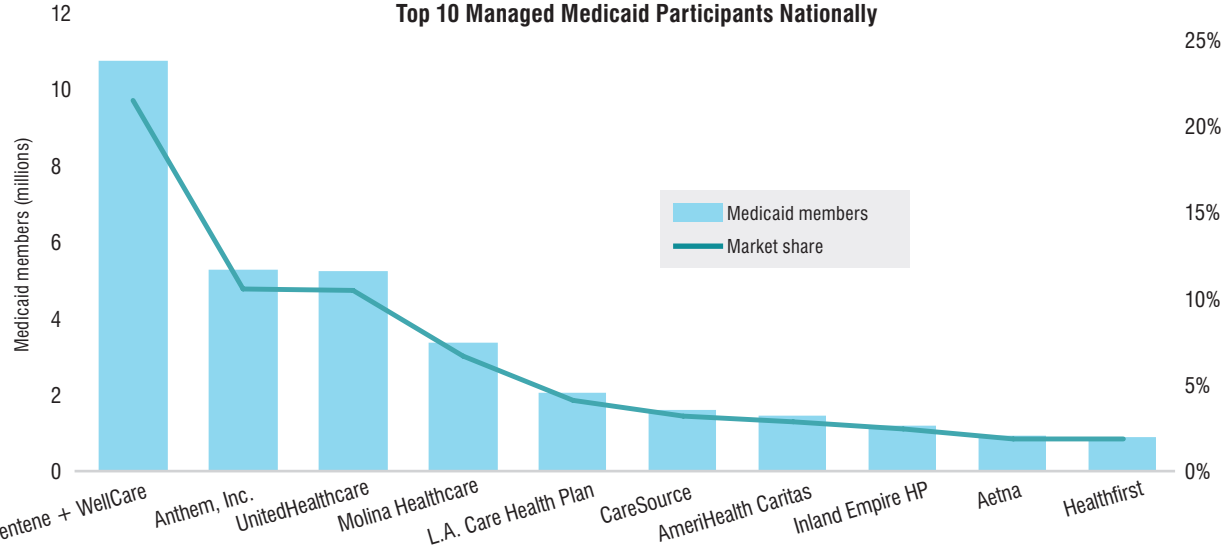
Centene/WellCare Rankings in Shared Medicaid Markets

State	Centene	WellCare	Combined
Arizona	4 of 8	5 of 8	1 of 7
Florida	2 of 12	1 of 12	1 of 11
Georgia	3 of 4	1 of 4	1 of 3
Illinois	3 of 6	1 of 6	1 of 5
Missouri	2 of 3	1 of 3	1 of 2
Nebraska	2 of 3	3 of 3	1 of 2
New York	1 of 18	10 of 18	1 of 17
South Carolina	3 of 5	5 of 5	2 of 4
National	1 of 142	4 of 142	1 of 141

Centene/Wellcare Combined Medicaid Market Share



Top 10 Managed Medicaid Participants Nationally



SOURCE: DHP, AIS's Directory of Health Plans. Visit https://aishealthdata.com/dhp.

A Monthly Update for *Health Plan Weekly* Subscribers

The AIS Report on Blue Cross and Blue Shield Plans

Tax Cuts Propel Not-for-Profit Blues Plans' Strong 2018 Financial Results

Not-for-profit Blue Cross and Blue Shield plans are reporting strong financial results for 2018, fueled by federal tax cuts approved by lawmakers in late 2017.

Health Care Service Corp. (HCSC), parent company of Blues plans in Illinois, Montana, New Mexico, Oklahoma and Texas, saw the most impressive results, with an after-tax income of $4.1 billion on $35.9 billion in total revenues, representing an 11% net margin, for full-year 2018. Other Blues plans also posted better-than-average after-tax income and net margin figures.

"Overall, we're seeing market strength again across all plans," says Ashraf Shehata, principal and health care leader at KPMG LLP in Cincinnati. Insurers' strong performance is fueled in part by higher premium rates in Affordable Care Act (ACA) individual market products, Shehata tells AIS Health.

"Last year we had a correction for ACA rates across the board," Shehata says.

"This year we also see ACA rate adjustments, but more in line with a standard rate adjustment," he adds. "Plans appear to be getting good rate increases from regulators, and on the back side, they're getting good rate concessions on provider contracts," Shehata explains.

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Blues' Social Determinants of Health Initiatives Cover Legal, Food Access

Blues plans are stepping up their efforts to address social determinants of health, with individual insurers initiating programs that try to help marginalized communities with healthy food access, transportation and even legal services.

For example, Anthem, Inc.'s Indiana Blue Cross and Blue Shield plan last month launched a new medical-legal partnership with Indiana Legal Services to provide free legal assistance to Medicaid members in central Indiana.

Although most of the legal issues addressed in the partnership don't directly affect health care status, they're important for enrollees' overall health and quality of life, says Kimberly Roop, M.D., president of Anthem's Indiana Medicaid plan. "We know Medicaid consumers have a broad range of civil legal needs, and providing access to attorney services will help remove a social barrier to their overall well-being," she says.

Studies show that people living in lower income brackets have more unresolved civil legal problems when compared with those in higher brackets. The inability to access legal services can result in loss of housing, domestic and child care disputes, and loss of employment.

The partnership between Anthem Indiana and Indiana Legal Services, which the insurer describes as "first of its kind," will offer free legal counseling for issues with housing and utilities; income support; education;

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employment; and family law, including guardianship, child support, child welfare and custody.

As a group, Blue Cross and Blue Shield insurers are ramping up their efforts to address social determinants of health, such as access to transportation and pharmacy services, poor nutrition and fitness deserts, in specific neighborhoods. Last year, the Blue Cross and Blue Shield Association launched the Blue Cross Blue Shield Institute, a subsidiary of BCBSA created to address these social and environmental issues, and announced that its first initiative would address transportation *(HPW 5/7/18, p. 9)*.

Lyft Delivers Rides to Enrollees

The Blues institute partnered with Lyft, CVS Health Corp. and Walgreen Co. to offer rides to pharmacies and primary care physicians, and in February expanded its partnership to Blues members in Medicare Advantage plans, who can access Lyft rides to appointments, pharmacies and fitness centers. Long-term, the institute hopes to determine whether the initiative lowers hospitalization and emergency room utilization.

Meanwhile, other individual Blues plans have launched their own initiatives around social determinants of health. Here's a look at three of them:

(1) Horizon Blue Cross Blue Shield of New Jersey is making plans to expand an initiative it began in Newark to identify social barriers to care for patients and work to connect those patients to health care providers.

The Newark Initiative, begun in 2017 as a collaboration with Robert Wood Johnson Barnabas Health (RWJBH), so far has identified 1,000 patients in four Newark ZIP codes who had gaps in care; chronic conditions such as diabetes, hypertension or heart failure; and who were frequent flyers in the emergency room, says Horizon spokesperson Thomas Vincz.

> **"These barriers include anything from lack of transportation availability to and from providers, and major distractions in everyday life that disrupt a person's self-focus on care, such as eviction, a family member in crisis and many other factors.**

Horizon claims data were used to identify the patients, and a care team of nurses, social workers and care assistants from both Horizon and RWJBH then met with the patients to determine "what social barriers stood between them and receiving proper care to address their chronic conditions," Vincz tells AIS Health.

"These barriers include anything from lack of transportation availability to and from providers, and major distractions in everyday life that disrupt a person's self-focus on care, such as eviction, a family member in crisis and many other factors."

The team then worked to remove those barriers and connect the patients to health care providers and other needed resources, he says.

Vincz says the one-year-old program "is still young but the year one results have been amazing," including a 25% reduction in total cost of care, 20% reduction in hospital inpatient admissions, 24% reduction in emergency room visits and 35% increase in visits to behavioral health providers. Horizon plans to work with more health care partners to turn the Newark Initiative from a pilot into a statewide program beginning later in 2019, he says.

(2) The Blue Cross and Blue Shield of North Carolina Foundation is giving $600,000 in grants to support six community-based collaborations across five counties. The projects will focus on social determinants to improve health and address inequities that cause health disparities.

The grants address a variety of issues, including:

- ***Food insecurity in low-wealth populations*** that drives obesity and diet-related chronic disease;
- ***Food inequity in children;***
- ***Inequities in farm worker and poultry processing worker populations,*** such as occupational hazards, poor housing, language access, lack of transportation and health care access;
- ***Stressors in marginalized communities*** that have contributed to a high prevalence of chronic disease and depression; and
- ***Food access, physical activity, transportation and youth engagement*** in "historically excluded" residents of rural Appalachia.

On the corporate side, the North Carolina Blues plan last year unveiled a $50 million investment into community health initiatives,

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with $15 million aimed specifically at social determinants of health, such as $2 million in funding to help provide consolidated and coordinated safety, legal and social assistance to victims of domestic and/or sexual violence.

For more information, contact Roop via Anthem spokesperson James Freeman at james.freeman2@anthem.com, Fine at Jori_B_Fine@bcbsil.com, Vincz at Thomas_Vincz@horizonblue.com and Blue Cross NC spokesperson Austin Vevurka at Austin.Vevurka@bcbsnc.com. ✧

by Jane Anderson

Blues Post Strong Financials

continued from p. 9

These strong results have the potential to continue through 2019, but this year's financial picture also will depend on Blue Cross and Blue Shield plans getting better control over their PBM and pharmacy costs, Shehata says.

Those efforts would involve taking a close look at their pharmacy benefit manager (PBM) arrangements, and also modernizing their accumulator benefit so consumers can see how much they've spent so far, he says.

Also on the consumer side, Shehata says Blues may consider investing in consumer-facing tools by improving their intake process and care coordination to help members choose high-performing providers. Finally, Blues plans are focusing on organic growth in the Medicare Advantage program.

"Every plan right now is trying to grow their Medicare Advantage," he says.

HCSC's 2018 results improved dramatically year over year from 2017, when the insurer posted $1.26 billion in income on $32.6 billion in total revenue, for around a 4% net margin. Significantly lower federal taxes accounted for the majority of HCSC's 2018 income.

Responding to the financial results, HCSC spokesperson Jori Fine says that the company has held rates steady and reduced them in some markets, "with our average individual Affordable Care Act rate changes between flat and -6.5% in our five states."

HCSC will "continue our efforts to stabilize or lower premiums for 2020, make investments in technology and improving the customer experience, and further our mission to expand access to care," she tells AIS Health, noting that HCSC's plans "serve individuals and families in every ZIP code" across the company's five states.

Other Blues plans also reported strong results.

✦ ***Blue Cross and Blue Shield of North Carolina*** posted after-tax income of $684.6 million on revenue of $9.9 billion for a net income margin of 6.9%. The insurer's net income fell from $734 million in 2017, and its net income margin also dropped from 7.8% year-over-year. Over the last five years, the company's net margin is an average of 3.3%.

Mitch Perry, the plan's chief financial officer, said a key driver of the company's 2018 performance was its ACA line of business, which performed better than forecasted "despite continued uncertainty and debate around health care in Washington."

Medical expenses rose about 3% despite a drop in membership of more than 2%, according to the company. Average annual claims per person climbed to an average of $5,326 per fully insured member, with injectable drugs and infusions, specialty drugs and treatments for chronic conditions such as hemophilia and anemia driving higher medical costs, Perry says.

✦ ***Blue Cross Blue Shield of Michigan*** reported an operating margin of $605 million on revenue of $29.3 billion for 2018, for a net margin of 2.1%.

Membership grew for the plan, especially in the small group market, which grew for the third year in a row, according to the company. These increases resulted from ongoing efforts to moderate insurance rates for small businesses, with nine quarterly rate reductions in the small employer market since 2015, the company said. The Michigan Blues plan also saw strong performance in the workers' compensation market by Blue Cross for-profit subsidiary AF Group, which brought in $187 million in positive margin, the company says.

Contact Shehata via KPMG spokesperson William Borden at wborden@kpmg.com, Fine at Jori_B_Fine@bcbsil.com or Perry via Blue Cross NC spokesperson Austin Vevurka at Austin.Vevurka@bcbsnc.com. ✧

by Jane Anderson

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How Blues Plans Fared in the 2019 Medicare Annual Election Period (AEP)

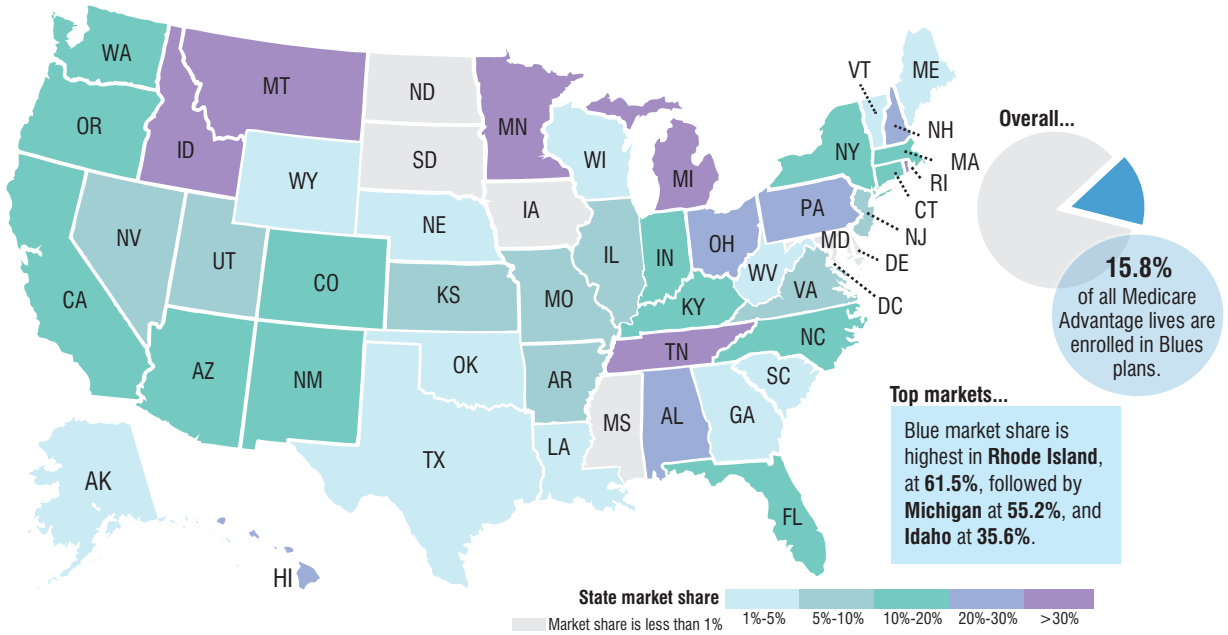
by Carina Belles

Blue Cross and Blue Shield plans enroll 15.8% of the overall Medicare Advantage (MA) market, with 3.47 million members as of February 2019. Blues plans generally fared well in the 2019 Medicare Annual Election Period, with enrollment growing by about 10% on average year over year. Market leader Anthem, Inc. grew by more than 50% due to its 2018 acquisitions of two Florida-based MA plans, America's 1st Choice and HealthSun Health Plans. Premera Blue Cross also experienced considerable growth by acquiring Washington's Soundpath Health in 2018. See the top 10 year-over-year membership increases below, plus Blues plans' state-by-state MA market share.

Top 10 Lives Changes in Blue Medicare Advantage Plans, February 2018 to February 2019

Insurer	State Markets	Current Enrollment	Change from 2018
BlueCross BlueShield of South Carolina	South Carolina	8,125	+279.1%
Blue Cross and Blue Shield of New Mexico	New Mexico	21,613	+98.8%
Premera Blue Cross	Alaska, Washington	33,428	+75.8%
Anthem, Inc.	Nationwide, largest presence in Ohio, Florida and California	1,085,911	+55.3%
Blue Cross and Blue Shield of Nebraska	Nebraska	1,372	+35.6%
Blue Cross of Idaho Health Service, Inc.	Idaho	31,979	+24.6%
Blue Cross and Blue Shield of Louisiana	Louisiana	12,692	+18.4%
Triple-S Management Corporation	Puerto Rico	125,821	+13.2%
BCBS of Western NY and BlueShield of Northeastern NY	New York, Florida, Pennsylvania and five others	55,176	+12.0%
Blue Cross and Blue Shield of Alabama	Alabama, Florida, Georgia and Tennessee	97,594	+11.8%

Blue Market Share in Medicare Advantage Plans, by State



NOTE: Puerto Rico is not pictured in U.S. map above. Blue market share in Puerto Rico's Medicare Advantage plans is 21.7%.
SOURCE: DHP, AIS's Directory of Health Plans. Visit https://aishealthdata.com/dhp for more information.

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