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Health Plan Week

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

Contents

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Insurer Consolidation Looks More Likely; Even UnitedHealth May Be on the Prowl

For years, consolidation has been part of the health care industry, with deals gigantic (Express Scripts Holding Co.'s takeover of fellow PBM Medco Health Solutions in 2013), deals strategic (Aetna Inc. acquiring Coventry in 2012 to shore up its Medicare business) and deals misguided (WellPoint, Inc.'s wild-eyed purchase of 1-800 CONTACTS in 2012). Simply put, merger and acquisition (M&A) activity among health plans and related industries is a common element of the business.

What has lacked is a whopping, huge Exxon Corp. buys Mobil Corp.-type of deal among health insurers. But from the looks of it, that era is going to come to an end, and possibly soon.

In what has turned into a mega-money guessing game, Wall Street insiders have told media outlets and *HPW* over recent weeks *(HPW 6/15/15, p. 6)* that any combination, or even two, among the five largest publicly traded carriers is a possibility. Since as far back as March talk has heated up about four of the five being in discussions about individual mergers (Aetna, Anthem, Cigna Corp. and Humana Inc.). But now *The Wall Street Journal* on June 15 said one of the biggest of them all, UnitedHealth Group, was in talks to buy Aetna, an eye-opener at many levels since UnitedHealth with its Optum money-making machine churning along was presumably not thinking about gobbling up another large carrier.

continued on p. 6

Some Insurers Seek Sharply Higher 2016 Premiums for Individual Exchange Plans

State and federal regulators are weighing proposed premiums for Affordable Care Act (ACA) exchanges in 2016 that include requests by some health insurers for steep increases, reflecting what actuaries call the reality of pricing for these still new marketplaces. Whether carriers get the total package of their proposed rates remains to be seen, but the requests are driven by insurers' realization that their exchange coverage has attracted an older, sicker crowd than they expected. And added to the medical cost factor is the uncertainty about whether the reinsurance, risk corridors and risk adjustment (3Rs) programs will pay out what HHS promised.

In looking at what insurers have submitted in various markets across the country, it's clear that after seeing what the first year of exchanges brought to bear in 2014, and what 2015 is shaping up to be, many insurers felt it was time for premium hikes for 2016.

For instance, in Delaware, for the 2016 plan year Aetna Inc. has proposed rate increases of about 16% for its individual HMO and PPO plans. Highmark Inc. is seeking rate hikes of about 22% for its health savings account-qualified plans, 24% for a PPO and 26% for its exclusive provider organization, according to CMS data for the federal facilitated exchange. And in Georgia, Blue Cross Blue Shield Health Care Plan of Georgia (a unit of Anthem, Inc.) is seeking rate increases of 12.4% and 15.8% for two individual plans, while Aetna unit Coventry wants to raise rates by 15.3% and 16.2% for a pair

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of plans. North Carolina's largest insurer, Blue Cross and Blue Shield of North Carolina, proposed a 26.2% increase for its Blue Advantage individual policy and 26.7% for its Blue Value product. The average rate increase was 25.7%.

All these numbers could, if approved by regulators, result in sizable premium hikes next year, and make the average rate rise of 5.2% across the ACA exchanges from 2014 to 2015 pale in comparison.

"This is still a learning period where health plans are putting out different prices and sometimes they end up attracting patients that cost them a lot more than they think. And when that happens that plays into rates," David Williams, president of Health Business Group in Boston, tells *HPW*.

And Julia Lerche, senior consulting actuary in Raleigh-Durham, N.C., for Wakely Consulting Group, says she is not surprised by insurers' actions. "I think going into 2014 and 2015 rate-setting there were just so many unknowns, it was really almost a shot in the dark in most states in terms of what the cost of the newly insured population would be. I think this is really a re-set based on actual experience that we are seeing now. It is not something we necessarily expect to continue to see year over year," Lerche adds.

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Williams says beyond asking for more premium dollars, health insurers are straightjacketed to some extent in what they can do in ACA exchange plans. He calls crafting more narrow networks kind of an "obvious" strategy, but otherwise "there is limited flexibility to change the overall benefit design because of the requirements with the essential benefits. And so the sorts of things you see are changes to the provider network, but also changes to the formularies for the pharmacy plans." But in the pharmacy benefit, Williams says "there have been some attempts by plans to discriminate by putting all the drugs for a given therapeutic category in the most expensive tier, even generics." Allegedly, this would keep people with HIV or hepatitis, for example, from enrolling in the products, he adds.

Another issue affecting insurers' 2016 rate requests is the 2015 baseline they are starting from, says Cori Uccello, senior health fellow at the American Academy of Actuaries. "Rates vary across companies and may partly depend on where premiums started off. You need to look at the increase itself and where premiums are. Are they getting closer together (between competitors)? Are lower premiums getting higher increases versus plans with lower increases? And of course the final caveat is that these are not final," she says.

Uccello estimates that medical trend is about 7% or so, and the reduction in the reinsurance program funding (see box, p. 3) is driving costs up another 3% to 5%. "Right there, you could be hitting 10%," she says, without factoring in utilization trends.

Consumers May Have to Shop More

Any increased premiums for 2016 should also be set against any subsidies paid out to the enrollee. "First of all, subsidies will rise as well if all the rates are going up and also the consumer has the opportunity to change from one plan to another. And what we are seeing is the lowest-cost plans and the second lowest cost plans, those premiums are not going up so much. So you might get a different plan you have to switch to," Williams says.

And given that most exchanges are quite competitive, the consumer should be able to shop at will. "As long as there are a lot of players to choose from, there is somebody else to offer a lower price. Still, we are seeing exchanges that are working from the standpoint there are a lot of players there. When you are hearing about rate increases, you don't hear about cancelling plans or products," he adds.

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Telemedicine Gains Traction, but Barriers Still Exist for Insurers

The field of telemedicine is growing, as heavy-hitters UnitedHealth Group and Walgreens Boots Alliance, Inc., expand their telehealth programs, and major vendors Teladoc and American Well clash in court. But barriers to access still exist, as issues with state medical licenses linger and state medical boards hesitate to greenlight a tool with the potential to threaten the physician-patient relationship.

Retailers and plans are embracing the new technology with gusto, increasingly rolling out 24-hour offerings on a variety of platforms. Walgreens, for example, first started offering mobile telehealth to customers in California and Michigan last December, and on June 10 said it is expanding its deal with telemedicine provider MDLIVE to all platforms in Colorado, Illinois and Washington in another step toward its goal of reaching 25 states by the end of the year. UnitedHealth Group is well invested in the game too, expanding the 24-hour virtual service in April to 47 states plus Washington, D.C. According to UnitedHealth, the investment in telehealth is worth it: a virtual visit costs less than $50, compared with a typical $80 doctor visit or $650 emergency room trip.

Now, Teladoc, Inc., one of the nation's largest telemedicine vendors, is going public. On June 17, Teladoc filed a Form S-1 with the Securities and Exchange Commission disclosing a projected $137 million initial public offering. But its ascent up the market ladder is not without obstacles: The company also is currently in a heated legal dispute with rival American Well Corp., which sued Teladoc for patent infringement on June 8 and prompted American Well Chairman and CEO Ido Schoenberg, M.D., to compare Teladoc to "1-800 catalog shopping" in a public statement. A spokesperson for Teladoc says the company is in a quiet period leading up to its IPO, but the company had previously denied the allegations brought in the suit.

Jonathan Linkous, CEO of the American Telemedicine Association (ATA), says the legal battle is a sign of the growing market, which is eliminating the access issues that once existed.

ATA recently began accrediting telemed programs, and while they've accredited only two thus far — those of American Well and HealthLinkNow — Linkous tells *HPW* more than 300 companies have applied. What's more, the applications are coming not only from independent telehealth vendors, but traditional health systems and pharmacies too.

Schoenberg says mobile technology has been a game-changer in the delivery of health care, citing Apple's new health data hub and its own platform that helps doctors improve how they "weave" telemedicine into their daily work schedule. "What we're seeing now is the evolution of a digital health ecosystem, which will better connect patients with clinicians and result in decreased cost, improved outcomes and quality of care," Schoenberg tells *HPW*.

But that doesn't mean telehealth is universally accessible. The barriers to access have changed, Linkous says, but they still do exist. Value-based care is gradually minimizing access issues to telehealth services, which

HHS to Pay 100% of Claims Under ACA's Reinsurance Program

HHS on June 17 said it would fully reimburse health plans for high-cost claims on public exchanges that exceed a certain threshold under the Affordable Care Act's reinsurance program, one of the three programs making up the 3Rs, or the reinsurance, risk adjustment and risk corridor premium stabilization protections.

HHS will now pay 100% of claims costs between $45,000 and $250,000, an increase from the 80% rate it previously stated. The department said last year it collected roughly $8.7 billion from carriers to fund the reinsurance program, which will expand by an additional $1 billion before November, HHS said.

Insurers funded the national reinsurance pool by paying a fee of $63 per person last year. That fee declines each year through 2016, when the reinsurance program is expected to have accumulated $25 billion in total.

Brian Wright, a securities analyst for Sterne Agee CRT, writing in a June 18 research note, said many health insurers had already accrued for the 100% reinsurance rate as early as mid-2014.

"We believe Anthem and Humana had already assumed 100% co-insurance in their estimates. Cigna, on the other hand, had assumed the 80% co-insurance rate," he said. Those carriers like Cigna who estimated at the lower rate would likely see modest earnings bumps this year, Wright added.

Read the HHS announcement at http://tinyurl.com/qjh4the.

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typically cost around $50 when not covered by a health plan or employer. The main issues involve state medical boards: licensing, since each state handles its own licenses and telemedicine physicians often connect with consumers across state borders, and a fear that too much reliance on virtual doctor appointments could lower the quality of care.

"I think from a patient safety perspective, that is a reasonable trade-off," says Russell Thomas, D.O., M.P.H., a family physician and member of the Texas Medical Association. The Texas medical board is locked in a legal battle with Teladoc over a rule it issued requiring patients to see a physician or other provider in person first before allowing them to continue a virtual relationship, a rule that a judge has ordered postponed until the court case is resolved. The controversy has reached the American Medical Association, which earlier this month tabled updates to its telemed guidelines for further review. AMA does not require an initial in-person meeting, which causes a conflict with the Texas medical board's stance.

Thomas is setting up a telemedicine service in Eagle Lake, Texas, that will provide services to a school for rural, at-risk youth nearly 400 miles away. With the help of a nurse practitioner and some high-definition equipment, Thomas can see inside a child's ear or throat better than he could in his own office. A Bluetooth-enabled stethoscope also allows him to listen to a child's heart and lungs with clarity, and the clinic is working on teleconferencing specialists such as cardiologists and internists in to Eagle Lake on days they're working from their base in Houston. But Thomas still values the requirement to see patients in-person first, as his nurse practitioner did before setting up the virtual office.

"Telemedicine is a tool, it's not a practice of medicine. I think it's still important in the practice of medicine that you have an established relationship with the patient," he says.

That sentiment is echoed by Linkous, who evaluates a number of aspects in accrediting a telehealth program, such as transparency for the consumer and an assurance the details of an online appointment are relayed back to the patient's primary care physician. A number of studies have reported positive results from telehealth use, and both providers and consumers are eager to try it. Richard Feifer, chief medical officer for Aetna Inc., says Aetna is seeing great success in its telehealth program with Teladoc, which is covered by 160 plan sponsors, adding that virtual delivery is "mainstream for group health plans right now."

It might soon be mainstream for other corners of the market as well, given the increased activity surrounding its use. The ATA reported in May that three more states had enacted telemedicine parity laws, bringing the total to 27 states plus D.C. In 2014, CMS reimbursed nearly $14 million in telehealth claims, and has considered expanding its usage.

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Medicaid Market Leaders for the Top 10 Medicaid States, 2015

State (Total Managed Medicaid Membership)	Company Name	Plan Name	2015 Enrollment	Medicaid Market Share in State
California (10,160,409)	Health Net, Inc.	Health Net Community Solutions	1,633,028	16.07%
	L.A. Care Health Plan	L.A. Care Medi-Cal	1,612,523	15.87%
	Anthem, Inc.	Anthem Blue Cross of California Medi-Cal	1,099,472	10.82%
	Inland Empire Health Plan	Inland Empire Health Plan Medi-Cal	1,028,878	10.13%
	CalOptima	CalOptima Medi-Cal	730,747	7.19%
New York (4,511,082)	Fidelis Care, Inc.	NYS Catholic Health Plan	1,073,160	23.79%
	Healthfirst	Healthfirst PHSP	913,097	20.24%
	UnitedHealthcare	UnitedHealthcare Community Plan	455,274	10.09%
	MetroPlus Health Plan, Inc.	MetroPlus Medicaid	417,460	9.25%
	Anthem, Inc.	HealthPlus Amerigroup	408,814	9.06%
Texas (3,005,552)	Centene Corporation	Superior HealthPlan	732,032	24.36%
	Anthem, Inc.	Amerigroup Texas	612,638	20.38%
	Texas Children's Health Plan	Texas Children's Health Plan STAR	314,715	10.47%
	Community Health Choice, Inc. (CHC)	Community Health Choice STAR	217,212	7.23%
	Parkland Community Health Plan	Parkland HEALTHfirst	173,875	5.79%
Florida (2,775,517)	WellCare Health Plans, Inc.	Staywell Health Plan	666,264	24.01%
	Centene Corporation	Sunshine Health	408,572	14.72%
	Anthem, Inc.	Amerigroup Florida	328,015	11.82%
	Prestige Health Choice	Prestige Medicaid	299,889	10.80%
	Humana, Inc.	Humana Family	296,431	10.68%
Ohio (1,705,043)	CareSource	CareSource Ohio Medicaid	957,962	56.18%
	Molina Healthcare, Inc.	Molina Healthcare of Ohio	234,877	13.78%
	Centene Corporation	Buckeye Community Health Plan	180,078	10.56%
	UnitedHealthcare	UnitedHealthcare Community Plan	174,965	10.26%
	Paramount Insurance Company	Paramount Advantage	157,161	9.22%
Michigan (1,606,323)	Meridian Health Plan of Michigan	MHP Medicaid	404,272	25.17%
	UnitedHealthcare	UnitedHealthcare Community Plan	257,712	16.04%
	Molina Healthcare, Inc.	Molina Healthcare of Michigan	234,385	14.59%
	McLaren Health Plan	McLaren Medicaid Health Plan	165,574	10.31%
	Priority Health	Priority Health Choice	102,611	6.39%
Pennsylvania (1,593,843)	AmeriHealth Caritas Family of Companies	Keystone First	302,029	18.95%
	UPMC Health Plan, Inc.	UPMC for You	255,957	16.06%
	Gateway Health Plan	Gateway Health Medicaid HMO	250,873	15.74%
	AmeriHealth Caritas Family of Companies	AmeriHealth HMO	187,290	11.75%
	Health Partners Plans	Health Partners	168,265	10.56%
Puerto Rico (1,428,690)	Triple-S Management Corporation	Triple-S Salud	1,428,690	100.00%
Kentucky (1,404,993)	WellCare Health Plans, Inc.	WellCare of Kentucky	510,104	36.31%
	Aetna	CoventryCares of Kentucky	414,128	29.48%
	University Health Care Inc., dba Passport Health Plan	Passport	279,032	19.86%
	Humana, Inc.	CareSource	124,123	8.83%
	Anthem, Inc.	Anthem Health Plans of Kentucky	77,606	5.52%
New Jersey (1,397,069)	Horizon Blue Cross Blue Shield	Horizon NJ Health	712,426	50.99%
	UnitedHealthcare	UnitedHealthcare Community Plan	433,350	31.02%
	Anthem, Inc.	Amerigroup New Jersey	194,797	13.94%
	WellCare Health Plans, Inc.	WellCare FamilyCare	52,466	3.76%
	Aetna	Aetna Better Health of New Jersey	4,030	0.29%

SOURCE: Calculated by AIS for the upcoming publication *AIS's Medicare and Medicaid Market Data: 2015*. Visit http://aishealth.com/marketplace/managed-medicare-and-medicaid-market-data for more information or to reserve your copy, or call (800) 521-4323. Data come from first quarter 2015 state Medicaid agency reports.

UnitedHealth Takes Look at Aetna

continued from p. 1

Cautioning that he takes everything as rumor until an official statement comes out, Vishnu Lekraj, senior health care analyst for Morningstar, Inc. in Chicago, tells *HPW* he believes "there is something in the works with one or two of these or several of these guys. And I wouldn't be surprised if there are some announcements here within a month." On UnitedHealth, he says the insurer does not need to make a move necessarily, "but they may feel differently than I do. I don't believe they have to make a move like the other MCOs. They are the largest issuer in the U.S., diversified and the management team seems to be very competent. It is a more plausible scenario we see a deal among the smaller three or Anthem buying one of the smaller three (Aetna, Cigna, Humana)."

A surprise for Ash Shehata, a KPMG partner who heads advisory services for U.S. health plans, is that the merger mania has come so early. "I think everybody was waiting for the consolidation to happen. But I think the issue that caught everybody by surprise was how quickly. We thought it would come a little bit closer to the election cycle," he tells *HPW*. There are plenty of reasons for the developments, like the interest among so many plans in bulking up on multiple lines of business, like Medicare Advantage (MA), where Humana is so strong.

Shehata says the looming implementation of the Affordable Care Act's "Cadillac" tax is also a factor, with the assumption employers will pull back on their benefits, leaving insurers with less commercial business. The tax will hit employers who offer high-cost coverage. For businesses offering health plans with premium costs above $10,200 for individuals and $27,500 for family coverage, they or their carrier will owe the IRS a 40% tax on the excess amount.

Additional News of the Week

Coverage of these health plan developments was included in this week's issue of *Spotlight on Health Insurers:*

- Audit Reveals Battle Between UnitedHealth, CMS
- Vt. Blues Seeks Repayment for Exchange Members
- Woman Allegedly Defrauded Highmark of $600K
- Insurers Push for Performance-Based Drug Prices
- Anti-Trust Suit Against Major Insurers Continues
- UPMC Asks Teacher's Group to Drop Highmark

Links to these additional news stories can be accessed at www.AISHealth.com/enews/spotlightonhealthinsurers.

Henry Loubet, senior vice president and chief strategy officer for Keenan in Oakland, Calif., and a former UnitedHealth executive, tells *HPW* there are an incredible number of issues to smooth out if a merger between large plans occurs, primarily because of state and federal regulations.

"Assuming plans operate in all 50 states, they would have to get approvals from each individual department of insurance and regulatory bodies, and in the case of California two," he says. This could result in any individual state forcing the acquiring plan to divest assets if there is a huge amount of overlap in a particular market. He points to this happening when UnitedHealth ventured deep into the Nevada market and bought Sierra Health Services, Inc. in 2007-2008 *(HPW 3/3/08, p. 1)*. "A plan could be required to sell part of their health plan membership and/or an asset or divest," he says.

"Then you've got all the employer group agreements from the acquired company. All need to be transferred to the new entity and the new entity has to follow all the enrollment and re-enrollment from clients," Loubet continues. This process could take 24 months to unwind, he adds. "Then on the provider side, you've got all the provider agreements, thousands of them. All need to be either taken over by the acquiring company or if there is overlap they need to be renegotiated to settle what the terms and conditions will be." That process could provoke conflicts between insurers and providers who may stake out harder lines to drive a better bargain.

Plans Could Run Into Challenges

Shehata views the mechanics of combining two large national insurers as "pretty complicated." He points to culture clashes as a top concern. "If we are seeing any of combinations we have heard about, United and Aetna or Cigna and Anthem, these are all very, very different cultural models that you are seeing. That culture is going to translate to broker networks, it translates certainly to the relationship with commercial clients and also translate to regulators," Shehata says.

On the other hand, provider contracts, in his eyes, are pretty comparable among the commercial carriers and would take much more time and effort to unravel if the deals were, say, between a Blue Cross and Blue Shield plan and a non-Blues carrier.

In the end, Loubet says health insurance has long been evolving into the "land of the giants," with just a handful of national plans remaining. "There are only so many properties to acquire," he says. And if a major takeover happens, there will be fewer jobs as administrative functions are a prime cutting area for carriers looking to cull costs.

The key at the broker level will be how a merger of giants impacts plan selection for individuals and groups, says David Mordo, owner of D Mordo Employee Benefits & Consulting, LLC, serving the greater New York City area.

"I don't view it to be a huge shock, but it puts the broker in a position quite honestly where it lessens the choice of products that a broker has to present to his or her client. So in the case of an acquisition of Aetna or Humana and their MA plans or Medicare Supplement plans, they are not going to keep an entire portfolio of two carriers. They are going to eliminate some products," he says.

This could mean shifting consumers to other plans, which may not have the same provider networks. Merger talk comes at a time brokers are especially attuned to the growing seniors market. "You take the Medicare market where 10,000 people a day are turning 65. It is a wonderful opportunity for a broker to do right by a client and increase their business. But these mergers of MA [plan operators] may hinder that," Mordo tells *HPW*.

Consolidation among health plans is nothing new to the brokers, he says, since many of them have been looking to do the same with their own businesses that are under pressure from Affordable Care Act reforms and the scarcity of carriers.

"At one time in New Jersey, there were 23 insurance carriers. Now it has compressed down to five or six over the last couple of years. The strong have survived, but brokers have had to merge their agency or get out. When you compress 23 down to five, life becomes very, very tumultuous for a broker who doesn't have that much to choose from anymore," Mordo adds.

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HEALTH PLAN BRIEFS

◆ **HHS Sec. Sylvia Burwell on June 15 informed the states of Arkansas, Delaware and Pennsylvania that each had the conditional approval of the agency to become state-based exchanges starting in 2016 ahead of a possible Supreme Court decision to strip subsidies for federally facilitated exchanges (FFE).** Each of the three states is an FFE, with Pennsylvania a pure HealthCare.gov state and Arkansas and Delaware in charge of some marketplace functions while the federal government handles the rest. If the Supreme Court rules against the Obama administration in the pending *King v. Burwell* case, tax subsidies for FFE enrollees may be eliminated *(HPW 6/15/15, p. 1)*. Read the approval letter for Arkansas at http://tinyurl.com/pkp35tj, for Delaware at http://tinyurl.com/pyl3tsj and for Pennsylvania at http://tinyurl.com/nrc63my.

◆ **The California state auditor on June 17 issued a report (2014-134) that slammed the California Department of Health Care Services' oversight of health insurers contracted under the California Medical Assistance Program (Medi-Cal), the state's Medicaid program.** "Health Care Services did not verify health plan data; therefore, it cannot ensure that the health plans had adequate provider networks to serve Medi-Cal beneficiaries," the auditor said, listing a virtual laundry list of problems with the way insurers did business. Other problems were that the insurers audited for the report, Anthem, Inc.'s Anthem Blue Cross, Health Net, Inc. and Partnership HealthPlan, had inaccurate provider directories. In response, Anthem tells *HPW* that it works in partnership with providers to create directories. "Anthem's contracts with providers require that they notify Anthem of changes in their contact information, network status, etc. When they fail to do so, despite proactive steps taken by Anthem to keep it current, the provider listing may become dated. Even when the provider listing is correct, Anthem relies on front office staff at doctors' offices to provide accurate information," Olga Gallardo, Anthem spokesperson, says. "However, in order to better serve our Medi-Cal members, Anthem has instituted additional steps to provide a more accurate directory including requesting physician rosters from medical groups twice a year." View the report at http://tinyurl.com/q2xcvf8. Contact Gallardo at olga.gallardo@anthem.com.

◆ **The HHS Office of Inspector General (OIG) on June 16 said CMS lacked the proper internal controls to ensure the accuracy of $2.8 billion in subsidies paid under the health reform law to insurers during the first four months that these payments were made.** "We determined that CMS's internal controls for calculating and authorizing financial assistance payments were not effective," HHS OIG said in its report (A-02-14-02006). Specifically, the watchdog said CMS's reliance on "issuer attestations"

HEALTH PLAN BRIEFS (continued)

failed to ensure that advance cost-sharing reduction payment rates identified as outliers were correct. CMS also did not have systems to guarantee that financial assistance payments were made on behalf of actual enrollees and in the proper amounts, among other findings. Visit http://tinyurl.com/p2cwupw.

◆ **Anthem, Inc. surpassed UnitedHealth Group in total membership,** according to a recent report from Mark Farrah Associates. The study analyzed enrollment for seven of the largest health insurers in the market, reporting that a 5.2% increase in total administrative services only and risk enrollment for Anthem tipped the scale against UnitedHealth, who reported a 1% loss in total enrollment. Anthem now claims 37.5 million members as of December 2014, compared with UnitedHealth's 36.8 million members. Visit http://tinyurl.com/nqzqzxf.

◆ **More than 75% of health exchange enrollees who tried to find a doctor found it easy or somewhat easy,** according to the latest tracking survey from The Commonwealth Fund. The survey, which polled exchange enrollees from March to May, also found that 67% of respondents were able to schedule an appointment within two weeks, although 26% had to wait 15 days or longer. Eight out of 10 respondents with exchange or Medicaid plans reported being satisfied with their coverage. Visit http://tinyurl.com/onzfevy.

◆ **CVS Health Corp. agreed to take over Target Corp.'s in-store pharmacy and clinic business for roughly $1.9 billion,** the companies said on June 15. CVS will continue to operate the more than 1,660 pharmacies inside Target stores under the name CVS/pharmacy in a "store-within-a-store" format, and rebrand Target's nearly 80 clinics as MinuteClinic. The two retailers have also committed to opening 20 new in-store clinics within three years of the deal's closing. Additionally, Target and CVS plan to open five to 10 "small, flexible format stores" under the TargetExpress name within two years. Visit http://tinyurl.com/q2zdmtg.

◆ **Former HHS Sec. Mike Leavitt (R) and five other former senior agency officials on June 15 released a letter offering advice to the governors and state legislatures of the 34 states where FFEs operate.** Writing for Leavitt Partners, a consultancy founded by Leavitt, the group's letter comes ahead of possible upheaval in the Affordable Care Act (ACA) marketplaces. The Leavitt letter presents possible scenarios if the plaintiffs win, including the chances for a legislative fix, possible administration efforts to save the subsidies and what states can do to transition to state-based exchanges, which would be unaffected by a ruling against the administration. Visit http://tinyurl.com/pj9znww.

◆ **HHS and the Labor and Treasury departments on June 12 released a final rule (80 Fed. Reg. 34292, June 16, 2015) to guide health insurers in making their coverage options more transparent for consumers to digest.** The Summary of Benefits and Coverage, for instance, now mandates that carriers provide online access to a copy of the individual coverage policy for each plan or group certificate of coverage. HHS said there were very few changes from the draft rule issued last December. Visit http://tinyurl.com/oewzv43.

◆ **Democratic presidential candidate Hillary Clinton told *The Des Moines Register* in an interview published on June 14 that while she supports the ACA, certain parts of the law should be corrected.** For instance, Clinton said the "family glitch," which blocks some low-income families from qualifying for tax subsidies, needs to be tweaked. She also told the newspaper there has to be a better way to "deal with the high cost of deductibles that put such a burden on so many working families," and expensive specialty drugs. Visit http://tinyurl.com/oy2hf2y.

◆ **Philadelphia-based Independence Blue Cross on June 15 said it is collaborating with Thomas Jefferson University and its health system (also based in Philadelphia) on a new innovation program starting on July 1.** "The Independence Blue Cross-Jefferson Health Innovation Collaboration will be jointly and equally funded by up to $2 million by Independence and Jefferson, and the program will be run through the Independence Blue Cross Center for Health Care Innovation and Jefferson's Innovation Pillar," the insurer said. The innovation center started in February 2014 to support health care entrepreneurism. The new collaboration will focus on ways to improve health care experiences, help people manage their own health, aid physicians and hospitals in transforming care delivery and develop future health care professionals. Visit http://tinyurl.com/q8z6owc.

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