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Health Plan Week

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

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Who's Making Money? UnitedHealth, Oscar Cut or Kill Commissions, Creating Worries

Another week, another series of seemingly dire signals from Affordable Care Act (ACA) exchange insurers that the expected bumpy ride to turning a profit on the marketplaces is going to have more potholes and outright pitfalls than anyone predicted. Maine's Community Health Options, the one Consumer Operated and Oriented Plan (CO-OP) that ever turned a profit, on Dec. 10 said it has cut off new enrollments for 2016 due to losses caused by steep medical benefit costs. And another start-up, Oscar Health, which is not a CO-OP and is worth around $1.5 billion as a result of massive venture capital love, told its brokers that commissions would be cut in half for New York ACA exchange sales.

Specifically, Maine's CO-OP said it lost more than $17 million in the first nine months of 2015. This compares to its $10.9 million profit for the same period of 2014.

Added to the news from the world of "small" players, the largest publicly funded carrier, UnitedHealth Group unit UnitedHealthcare, which has caused more than a little spilled ink in the media over its recent statements that it may exit ACA exchanges if things don't turn around, informed its brokers that it will eliminate altogether any commissions for individual marketplace sales. The company issued a statement, but not much more: "Our current actions are consistent with our long-stated approach to continually evaluate the dynamics of exchanges as they evolve and adjust to changes in the market accordingly," Lynne High, UnitedHealth spokesperson, tells *HPW*.

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Horizon OMNIA Firestorm in N.J. Could Be Harbinger of More Tiered Network Disputes

The fight over Horizon Blue Cross Blue Shield of New Jersey's new OMNIA health plan reached a fever pitch after state Senate Democrats on Dec. 7 introduced a quartet of bills in the legislature that would restrict or delay the plan's implementation. A string of factors led to the unique backlash in New Jersey, industry observers say, but the fight could be a precursor to national pushback from providers and consumers against tiered and other narrow network products.

One of the bills would impose a moratorium on new tiered plans introduced in 2015 until Jan. 1, 2017, and allow consumers who have already chosen a tiered plan the option of selecting another. The second bill would increase transparency in the insurer's process of selecting and placing providers in tiers, an issue because critics say Horizon did not provide enough detail on why it chose certain health systems for its preferred tier. The third and fourth bills aim to implement minimum benefits and block regulators from approving incomplete tiered plans.

Mike Mascolo, New Jersey-based employee benefits national practice resource leader for Wells Fargo Insurance Services, tells *HPW* the uproar over the OMNIA plan *(HPW 9/14/15, p. 8)* could be a harbinger of things to come on the national stage.

"Obviously there's been a lot of media attention here in New Jersey, but I do think it's an emerging national issue," Mascolo says. The rising prevalence of accountable

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designs]. I think they knew they had some time to make those decisions before the tax went into effect," he says. "Most carriers have had the discussion and had it out there as they designed plans for next year, but I have not seen any of them [insurers] aggressively change plan designs until there is clarity on an appeal or delay. And now with the political pressure the likelihood of a delay seems much greater than I think that it has ever been."

Whether the tax is removed completely or temporarily, it means some employers will continue to offer more expensive benefits. "There is obviously still a market for them and those constituents," Shehata says. "It also means you will probably see out-of-pocket contributions continue to rise just because premiums have increased but I think still you will see those [high-dollar] plans being offered to unions and executives as part of their pay packages." The reason for that is that Blue Cross and Blue Shield plans and national insurers are "very well situated to offer those [richer plans]" through their broad PPO offerings with provider networks.

Bipartisan Love Is Seen for Killing the Tax

Repealing or delaying the tax has strong support among Democrats looking out for their union constituencies and Republicans vouching for their business backers. Union benefits and senior level executive plans would be the main targets of the excise tax, although an analysis by Towers Watson & Co. said the tax would hit many more types of benefit plans, projecting that nearly half of employers with at least 5,000 employees that offer health plans could be slammed by the excise tax in 2018, with that number growing to 82% by 2023.

Regardless of the breadth of the tax's potential impact, the bipartisan alignment against it is impressive, considering the lack of any agreement on health care-related issues in Congress. Further proof of this bipartisan power came on Dec. 9 when the Alliance to Fight the 40 coalition said it counts 291 members of the 425-member House in favor of repealing the tax. Supporters of the Cadillac tax include President Obama, as well as some economists and a small minority of congressional Democrats, who fear gutting the tax will deplete the ACA of some $87 billion in funding from 2018 through 2025. Backers also believe repeal or a delay could embolden anti-ACA actions such as repealing the employer and individual mandates, among other steps a future administration and Congress may undertake.

On Dec. 9, the White House said it opposes any alteration to the Cadillac tax as written into the reform law, but interestingly did not go as far as to threaten a veto of the tax extenders bill that contains the provision. In a largely show vote in the Senate on Dec. 3 to repeal core components of the ACA (52-47 in favor), an amendment to eliminate the Cadillac tax sailed through with a 90-10 majority, displaying the muscle this movement has *(HPW 12/7/15, p. 8)*. Obama has promised a veto of the ACA repeal bill, H.R. 3762, after it is reconciled with the House version and sent to his desk.

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Additional News of the Week

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

- Cigna Refuses Coverage of 3D Mammograms
- Calif. Blue Shield CEO Disputes Charity Obligations
- Independence Launches Counseling Service
- United Sees Success in Home Visit Program
- Cigna Shareholders Approve Anthem Deal
- Kaiser Ordered to Pay for Out-of-Network Care
- Judge Rules Out State Claims in Anthem Breaches
- Cigna Launches Collaboration With Seton

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

Insurers Slash ACA Commissions

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For its part, Oscar in a letter to brokers said the New York marketplace offers "extraordinary circumstances." And while it recognizes that halving commissions "will add to your challenges at an already difficult time…this change is necessary to ensure we are able to grow our business in a controlled manner and can continue to offer a great experience to all of our members," according to Oscar spokesperson Cat Cuppernull.

She stresses this change impacts only New York brokers, as the insurer also does business in New Jersey, Texas and California. Market observers in New York tell *HPW* the New York ACA exchange space has been riled by the loss of Health Republic, the CO-OP that went belly up this fall *(HPW 10/5/15, p. 1)*, leaving its members to scramble for new coverage, with many going to Oscar.

"Yes, Oscar has significantly reduced their commissions with practically no advance notice. There was also a recent *Crain's* article explaining that Oscar is still losing tens of millions of dollars annually. At the new commission levels it is impossible to provide hands-on service to individual clients and remain profitable as an agent," David Capo, a broker for Benefits Advisory Service, Inc. in New York City, tells *HPW*. *Crain's* said Oscar cut brokers'

payments from $14 per contract per month for individuals and a high of $26 for families to a flat $6 per contract each month for all individual and family policies. Oscar has bled $41.5 million for the first nine months of 2015 after losing $27.5 million for 2014.

Market consultant Chris Condeluci, a principal at CC Law and Policy, said Oscar's move may be in reaction to UnitedHealth's posture on commissions, but in the end Oscar is still losing money. "Part of me thinks Oscar is simply being opportunistic here. But, as stated, Oscar lost money in 2014, and Oscar only received close to $2 million on a $15 million 'risk corridor' payment request (indicating that Oscar insured higher risk individuals in 2014). It appears that for 2015, Oscar doubled its premium revenue and enrollment, but its medical claims tripled," he said. "To me, this is just another example of the current problems in the individual market. So, I say to the ACA proponents, it's not just UnitedHealth who is hurting here."

MLRs Get the Finger for Commission Cuts

Brokers say the newest developments from UnitedHealth on ending commissions for ACA sales, which also goes for off-exchange individual policies, is part and parcel of something they have been warning of since the reform law's inception *(HPW 10/26/15, p. 1)*. "The Medical Loss Ratio (MLR) is the driver of the change to zero agent compensation. United Healthcare will sell their individual products using the HealthCare.gov call center and government paid navigators. United Healthcare may also have an internal call center," agent Rick Bailey, president of Rick Bailey & Company, Inc., based in Woodstock, Ga., tells *HPW*.

"A consumer goes to HealthCare.gov and pays the same premium currently with or without an agent. Why would you not select an agent to assist you? The new choice will be you can save money by going directly to the insurance company or HealthCare.gov. If you want an agent, you will need to pay an extra charge or fee."

The end game, he says, is no independent agent will be paid to assist consumers with their decisions. "How can someone that needs assistance to pay their premium afford to pay an agent a new and separate fee?" Bailey asks. "The original idea behind MLR was to force insurance companies to get their operations leaner and provide a better value to consumers. The results are that the insurance companies are providing the consumer with less value (paid advice of an independent agent) and

Health Insurer Stocks Tank After UnitedHealth's Warning on ACA Exchanges

Health plan stocks suffered a major dip after UnitedHealth Group's Nov. 19 announcement that it is considering leaving the exchanges in 2017 *(HPW 11/23/15, p. 1)*. While most of the 10 stocks *HPW* tracks rebounded somewhat before the close on Nov. 30, only Cigna Corp. was able to finish in the black for the month, posting a meager 0.9% gain. Aetna Inc. and WellCare Health Plans, Inc. took the biggest hits, dropping 10.9% and 8.8%, respectively. Investors are particularly bearish on Universal American Corp., with a 2015 consensus price-to-earnings ratio of -162.6. The stock is down 17% year-to-date.

	Closing Stock Price on 11/30/2015	November Gain (Loss)	Full-Year Gain (Loss)	Consensus 2015 EPS*	Consensus 2015 P/E Ratio* (Negative)
COMMERCIAL					
Aetna Inc.	$102.75	(10.9%)	15.7%	$7.55	13.6 x
Cigna Corp.	$134.98	0.9%	31.3%	$8.60	15.7 x
Health Net, Inc.	$63.26	(3.0%)	19.3%	$3.32	19.1 x
UnitedHealth Group	$112.71	(5.0%)	11.8%	$6.00	18.8 x
Anthem, Inc.	$130.38	(6.8%)	3.9%	$10.19	12.8 x
Commercial Mean		**(5.0%)**	**16.4%**		**16.0 x**
MEDICARE					
Humana Inc.	$168.66	(6.6%)	18.0%	$7.75	21.8 x
Universal American Corp.	$7.48	(1.6%)	(17.0%)	($0.05)	(162.6) x
Medicare Mean		**(4.1%)**	**0.5%**		**(70.4) x**
MEDICAID					
Centene Corp.	$57.75	(5.2%)	10.6%	$2.87	20.1 x
Molina Healthcare, Inc.	$60.26	(7.2%)	14.9%	$2.69	22.4 x
WellCare Health Plans, Inc.	$82.48	(8.8%)	2.0%	$3.44	24.0 x
Medicaid Mean		**(7.1%)**	**9.2%**		**22.2 x**
Industry Mean		**(5.4%)**	**11.0%**		**0.6 x**

* Estimates are based on analysts' consensus estimates for full-year 2015.
SOURCE: Bank of America Merrill Lynch. Compiled by Atlantic Information Services, Inc., December 2015.

forcing the consumer to find someone that will help them and charge them a fee."

He says it would be interesting to call agents in Massachusetts, where their exchange does not pay a commission on individual health policies, to find out how few of them will help even for a fee. "It is a market they do not want to spend the time to be knowledgeable in. The next game will be the two-to-50-employee small group market," Bailey adds.

Insurers May Just Be Seeing Growing Pains

With CO-OPs dropping like flies, UnitedHealth writing down $425 million in ACA exchange losses *(HPW 11/23/15, p. 1)*, and now the commission cuts, it would seem there is little good for the marketplaces. But some market consultants say not so fast on writing them off, and not so fast on reading too much into UnitedHealth zeroing out commissions as a possible precursor to a segment departure.

First, some insurers, like Anthem, Inc., have said they are making a little money on exchanges. And a *Los Angeles Times* report on Dec. 9 said three of the state's insurers doing business on Covered California racked up sizable profits, benefitting from the state exchange's positive mix of sick and healthy enrollees. The report said Blue Shield of California made $107 million, Kaiser Permanente $66 million and Anthem Blue Cross $9 million in 2014.

And some of the losses for, say UnitedHealth, can be explained by the unique nature of individual marketplaces, which is not what the carrier is known for. "Under-

Supreme Court Seems to Lean Against State in Health Data Case

Following oral arguments in the Supreme Court's *Gobeille v. Liberty Mutual Insurance Co.* (14-181) case on Dec. 2, a top health care lawyer tells *HPW* it is clear to him that the justices who spoke don't think too much of Vermont's claimed authority to require "all-claims data" from the plaintiff, Liberty Mutual Insurance Co., as the state is arguing.

"I think the state is going to lose," predicts Stuart Gerson, an attorney in the Litigation and Health Care and Life Sciences practices at Epstein Becker Green, stressing that even liberal justices seemed skeptical of Vermont's push for claims data from self-insured entities, which are not regulated by the state. The fact liberal justices asked tough questions of the state during oral arguments is important because these justices, like Stephen Breyer, usually favor the government and its reach.

At issue is a law in Vermont requiring health plans, including self-insured plans, to submit health care data to the state's database of health insurance claims and other information in an effort to find ways to lower costs and improve care.

The U.S. Court of Appeals for the Second Circuit in New York City (12-4881) ruled against Vermont by declaring that self-funded plans are protected from state insurance regulation under the Employee Retirement Income Security Act (ERISA) *(HPW 7/13/15, p. 1)*. But the Supreme Court decided to take the case on appeal.

Gerson says the "foot-in-the-door" mentality is what has insurers' attention since 18 other states have laws that created all-payer claims databases, while 20 more are considering similar legislation. In the end, however, Liberty could win on its argument that the burden of providing data is too great.

"My guess is that for a variety of reasons it may be ultimately that some of the justices will suggest that there be some kind of federal data collection, which is questionable given that insurance is regulated by the states," Gerson says. "It is a balancing question. A number of justices are sympathetic to the issue of states collecting data from all comers, including the groups that they actually regulated and comparing it to others to have a fund of data related to health care usage claims and so that they can set their own policies in the future."

But, he says, it seems the regulation question is a sticking point. "We live in an era of big data and I think there is sympathy generally for anyone collecting it, and having a set forth reason to use it. However, the state does not regulate the entity in question. Its authority is questionable and for multi-state employers there is this overhanging issue of potentially being subject to the different kinds of requests from a variety of states, or maybe even all of them if a company involved is big enough," he explains.

The battle is between the good that may come from collecting the data versus the expense, burden and time on the other. "That is the reason it becomes problematic," Gerson says.

A court decision will likely not take that long considering it is not a complicated case, he adds.

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writing in the individual market is much, much different than the group market and so I think that there may not be as much experience from an underwriting and positioning approach (for some players like UnitedHealth)," Henry Loubet, senior vice president and chief strategy officer for Keenan in Oakland and former CEO of UnitedHealthcare's Western operations, tells *HPW*. Add to this the fact UnitedHealth did not take part in many exchanges in 2014, and has had less time to learn from its mistakes like Aetna Inc. and Anthem did, he says.

Loubet also says it is clear that a company like UnitedHealth cannot afford to subsidize its participation in ACA exchanges if it cannot turn a profit, and there is the matter of HHS not coming through on 3Rs reimbursement as was promised in the ACA. "The feds, to be fair, with the risk adjustment, reinsurance and risk corridors piece, must have some way to provide more funding to United and others," he says.

CMS Says There Are No Extensions

CMS may have also done insurers a favor by declaring there would be no special enrollment period for 2016 (see brief, below). "Special enrollment for a number of issuers has been a challenge, especially with the extension in the open enrollment period last year that was not necessarily known at the time of pricing," says Scott Weltz, a principal and consulting actuary for Milliman. "We continue to look at that across our databases as well, but in some instances for certain insurers you can look at two to three months of claims for some of these individuals that amount to what typically would be a year's worth of claims. So that is definitely a challenge pricing wise because the risk adjuster does not account for that in a similar fashion."

For the last bit of favorable news, on Dec. 9 CMS said plan selection has been strong on federal marketplaces, with more than 1 million new enrollees now having selected coverage for 2016.

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HEALTH PLAN BRIEFS

◆ **Kaiser Permanente agreed to purchase Group Health of Seattle, Washington adding some 500,000 to 600,000 members to the Kaiser portfolio.** In a Dec. 4 statement, the insurer said pending approval by Group Health Cooperative members and regulatory approvals, the two organizations will combine operations. No terms of the deal were disclosed. "The process to complete this transaction will take about a year and many of the specifics will be developed together in the coming months," Kaiser said. Visit http://tinyurl.com/hklmh4w.

◆ **America's Health Insurance Plans (AHIP), still going through the transition to new CEO Marilyn Tavenner after the departure of longtime head Karen Ignagni *(HPW 5/25/15, p. 7)*, on Dec. 7 said two top executives are leaving by year's end.** AHIP spokesperson Clare Krusing tells *HPW* that Mary Beth Donahue, who has served as executive vice president for more than a decade, and Dan Durham, who most recently was interim CEO, are resigning from the organization. Contact Krusing at ckrusing@ahip.org.

◆ **CMS released guidance on how it will implement automated payments for federal public exchanges,** according to a posting on REGTAP.info and a Dec. 9 blog post in *Health Affairs* by Affordable Care Act observer Timothy Jost, a law professor at Washington and Lee University. "As of January 2016, CMS will finally be implementing an automated payment approach, called policy-based payments. This system will be based on the exchange between federally facilitated marketplaces and insurers of individual-enrollee-specific IC 834 enrollment and payment transaction data. These data will be updated daily," Jost said. The new guidance also puts in place a policy under which CMS will partially withhold payments from insurers whose data is not considered ready for a timely transition to policy-based payments. For more information, visit http://tinyurl.com/zsgdqr5.

◆ **HealthCare.gov CEO Kevin Counihan in a Dec. 7 blog post reminded consumers that the final deadline to sign up for plan year 2016 coverage via HealthCare.gov is Jan. 31.** "A Special Enrollment Period around the April 15 tax filing deadline will not be offered this year. If you don't enroll by then, you could have to wait another year to get coverage and may have to pay the fee when you file your 2016 income taxes," he said (see story, p. 1). Visit http://tinyurl.com/hn9x2uk.