Volume 27, Number 29 August 21, 2017

HEALTH PLAN WEEK

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

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*PUBLISHER'S NOTE: **HPW** will not be published next week. The next issue will be dated Sept. 4.*

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State Health Laws Are 'All Over the Map' In Effort to Exert Control Over ACA's Future

States have been caught in the middle of the debate in Washington over the Affordable Care Act, forcing a response to continued uncertainty over the ACA's future. Some states have passed bills to ensure progress under the ACA goes uninterrupted, others have passed laws to block portions of the ACA as best they can, and still others have yet to make a move. But despite how efforts to repeal and replace the law pan out, states will be pivotal in the years ahead in reforming U.S. health care, industry insiders say.

Richard Cauchi, program director on health insurance, finance and pharmaceuticals at the National Conference of State Legislatures (NCSL), says this year has been "an active, yet challenging session for many states, due to the uncertainty resulting from multiple pending bills in Washington and no final resolution as of mid-August. Despite this, several states did enact new laws." But, "there isn't a single theme to what states did this year." No matter what happens on the federal level with the ACA, "states are the innovators and the incubators," playing a major role in designing health care.

Sara Collins, vice president of health care coverage and access at the Commonwealth Fund (CWF), an ACA proponent, says marketplaces and enrollment are the key policy concerns right now for states. CWF surveys have revealed that personal enrollment assistance provided by navigators made a difference in the number of people who signed up for Medicaid under the ACA expansion. Some states have passed laws to make it more difficult for navigators to help enrollees. But now, bipartisan approaches are beginning to surface about the best ways to ensure that eligible people can enroll. There is a shift in the discussion toward policy fixes, she says.

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CMS Extends Plans' 2018 Filing Deadline, Pitches Formula Changes If CSR Pay Is Lost

Without fanfare, CMS on Aug. 10 distributed a short memo to Affordable Care Act (ACA) exchange plans that are uniformly struggling with 2018 marketplace uncertainties as final premium-rate filing deadlines approach. Federal regulators outlined proposed changes they said they intend to make if the Trump administration were to halt federal cost-sharing reduction (CSR) payments to plans. Some industry analysts say it seems that the Trump administration, which has agreed to make CSR payments for August, is pre-emptively preparing to halt plans' reimbursement — since otherwise the guidance would not be needed.

In its three-page document, CMS said it intends to propose modifying the risk-adjustment methodology that now assumes insurers will get federal CSR payments. CMS also extended the final rate filing deadline for 2018 federally facilitated exchanges from Aug. 16 to Sept. 5. This gives plans three weeks of extra time to evaluate how the agency's proposed changes to the formula — aimed at equalizing risk among carriers — could affect their premium rates and adjust them accordingly.

Attorney Christopher Condeluci, principal of CC Law & Policy in Washington, D.C., and a former GOP staffer for the Senate Finance Committee during the ACA's drafting,

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

says he doesn't think pushing back the rate filing deadline is the most noteworthy part of HHS's guidance. "Many analysts — including me — think that the changes made to the 'risk adjustment' formula [are] a sign that the cost-sharing subsidies may NOT be paid by the Administration," he said in an Aug. 17 policy and regulatory update.

"If the Administration was going to fund the cost-sharing subsidies, then this guidance would NOT be needed," Condeluci wrote. "After all, the carriers would NOT need to increase their premiums because they would know the cost-sharing money would be coming. BUT, because it appears that the Administration is anticipating a scenario where the unfunded cost-sharing liabilities WILL be loaded on to the premiums of a 'silver' Exchange plan, it is almost as if the Administration is preemptively preparing for such a scenario."

From an actuarial perspective, the effects "will vary considerably by carrier and it's premature to say how significant it could be," Jim O'Connor, principal and consulting actuary in the Chicago office of Milliman, Inc., said Aug. 15. For some carriers the impact might be minimal, while for others it might be material, he said. "Some plans will be positively affected and some plans will be negatively affected," he added.

O'Connor said he doesn't expect additional double-digit increases or decreases in next year's premium rates due to CMS's proposal. He said the agency's move could have some influence on plans' decisions on whether to participate in exchanges for 2018, but state insurance departments currently are having "a lot of dialogue" with insurers about how best to approach changes in the market and continue to offer coverage to individuals.

"Those plans that tend to have more CSR business than the average will be more negatively affected…and those plans with less CSR business and maybe more bronze [metal tier business] would be positively affected," O'Connor said Aug. 15. He said Milliman expects to release a draft analysis of CMS's risk adjustment proposals in the near future, and is developing a tool for clients "to model what the impact may be to them."

Under the new timeline, the states and CMS will review modified plan rate filings for 2018 from Sept. 6 through Sept. 19. CMS expects to post all final rate filing information for plans on Nov. 1. (If a state chooses not to allow issuers in their state to modify their 2018 rate filings, CMS is asking the state to inform the federal agency of this no later than Sept. 5.)

Five days after CMS issued its memo, the Congressional Budget Office (CBO) said terminating CSR payments would prompt plan exits, boost silver-plan premiums and increase the federal deficit by $194 billion from 2017 through 2026 (see brief, p. 8). On Aug. 16, President Trump made the issue moot for at least another month, saying he would make August CSR payments.

Senate Health Committee Chair Lamar Alexander (R-Tenn.) said Trump's move helps the millions of Americans who buy health insurance on the individual market. "Congress now should pass balanced, bipartisan, limited legislation in September that will fund cost-sharing payments for 2018 as well as make section 1332 [of the ACA] work better to give states more flexibility in approving insurance policies," he said in a statement. "These two actions will help make insurance policies available at affordable prices." He said his panel will begin hearings on stabilizing the individual market the first week of September. "Congress should act before the end of September to keep insurance available at a reasonable cost during 2018," he said.

CMS Memo Adjusts Formula

In its memo, CMS noted that many state insurance departments "have permitted issuers to increase rates for their silver metal level plans for the 2018 benefit year in order to account for uncompensated liability that issuers may face [for CSRs provided to eligible individuals]." As a result, CMS said it "intends to propose a modification to the HHS risk adjustment methodology in future rulemaking for states in which all marketplace issuers in-

Health Plan Week (ISSN: 1937-6650) is published 45 times a year by AIS Health, 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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crease silver metal plan rates to account for cost-sharing reduction payments in this manner."

Here is how O'Connor, the actuary, explains the agency's solution, as outlined in the memo:

◆ ***CMS's current risk adjustment transfer formula*** uses a 70% actuarial value (AV) for CSR plans even though their actual AVs are 73%, 87%, or 94%, depending on the CSR plan variant. (CSR-eligible enrollees qualify for one of these plan variants based on their income level.) However, the formula allows the higher service utilization levels anticipated for these plans to be accounted for in an adjustment to the risk factor for each CSR individual. This is done since theoretically plans now get federal reimbursement for the higher benefit levels provided by the plan variants over a standard 70% AV silver plan, but not for the increased utilization of medical services.

◆ ***The new formula proposed by CMS for 2018*** — in the event the government ceases paying the differences between the CSR plan variants and the standard 70% silver plan — treats the 87% and 94% plan variants as platinum plans (90% AV) instead of as silver plans. It removes the utilization adjustment used in the current formula from the risk score, since it now will use the standard utilization factor and AV for a platinum plan, and treats the 73% plan variant as a silver plan with a 70% AV.

Risk Adjustment Remains 'Zero-Sum Game'

"I can say it will affect health plans differently, depending on how much CSR business they have or expect to have in 2018," O'Connor said. "It depends on where your distribution lies and your distribution change in your metal plan relative to other carriers in the state. The risk adjustment program will remain a zero-sum game. It just shifts who is going to pay into — and get paid out of — the risk adjustment program."

According to O'Connor, a carrier "whose distributions now and after formula changes are representative of state averages are not likely to be affected a lot. But carriers with distributions relatively different from the state average can be affected favorably or unfavorably."

O'Connor said it wasn't a surprise that CMS was looking into risk adjustment and ways to improve the formula. "But for most of us, it was a surprise, I think, this change due to [the possibility of halted CSR payments]," he said. What's the overall significance of CMS's proposed changes on a scale of one to 10? "I don't think it's a 10, but it's not a one either," O'Connor said. "It's somewhere in the middle."

Contact Condeluci at chris@cclawandpolicy.com and O'Connor at jim.oconnor@milliman.com. Find CBO's report at http://tinyurl.com/ybd4qyk4 and CMS's memo at http://tinyurl.com/yckv6egc. ✧

by Judy Packer-Tursman

As Congress Looks at ACA Again, Waivers Are Next Wave in Medicaid

Congress has set the stage for a September return to debate on stabilizing the individual health insurance market, with major changes to Medicaid funding or expansion taking a back seat. But industry experts warn that health plans and other stakeholders should keep a close eye on conservative-minded Medicaid waivers that states may use to scale back enrollment and eligibility.

The Trump administration's favorable view of Section 1115 demonstration waivers containing so-called conservative principles could really set expansion back, says John Gorman, founder and executive chairman of Gorman Health Group.

Kentucky, for example, recently amended its waiver proposal to revise current terms of Medicaid coverage by linking "employment activities" to Medicaid eligibility. That proposal also includes a six-month "lockout" period, where individuals may not re-enroll in the program for six months if they don't pay their past due premiums. According to Families USA, Indiana is the only state Medicaid program with an approved lockout provision.

"I think it's the waiver process that's going to be [used] first and foremost in cutting eligibility and making it more difficult for people to enroll...with very adverse implications for both health plans and for members," observes Jerry Vitti, founder and CEO of Healthcare Financial, Inc., a company that connects low-income, elderly and disabled populations with public benefit programs. "More folks will be coming on and off Medicaid, and you're going to have adverse selection because you'll have only the sickest people on the plan," he predicts. "Plans won't get the premiums until people come back on, when they are generally sicker and have untreated ailments that will be costly. It's a very sneaky and insidious way of lowering costs, just because of the sheer volume and churn in the population."

> **"It's the waiver process that's going to be [used] first...in cutting eligibility and making it more difficult for people to enroll...with very adverse implications for both health plans and for members.**

Gorman points to CMS's recent approval of a five-year extension of the Managed Medical Assistance demo in Florida, which is one of 19 states that did not expand Medicaid under the ACA.

"Under New Era of State Flexibility," declared the Aug. 3 press release from CMS unveiling the waiver extension that includes an additional $900 million in

Low-Income Pool funding, which enables health care providers to provide more care to uninsured or underinsured Floridians rather than expands coverage. "Basically, what [CMS Administrator Seema Verma] is saying is this administration prefers charity care to health insurance. If Florida got that approved, Kentucky's next, and I think this is much more of what you're going to see from the Trump administration," predicts Gorman.

"There'll be a domino effect," adds Vitti. "The idea of attacking Medicaid costs and eligibility and enrollment will happen one state at a time. There's no turning back."

As for how Medicaid MCOs should prepare, it varies "wildly" by state, says Gorman. "What a Medicaid plan has to do in Florida is going to be very different than what a plan in an expansion state has to worry about," he remarks.

"But generally, we tell them, 'Get back to basics, make sure that core administrative functions that impact revenue, like risk adjustment, are running like a Swiss watch, and that your clinical infrastructure and processes are person-centered and supportive, not restrictive.'"

Contact Gorman at jgorman@gormanhealthgroup.com and Vitti at gvitti@hfihealthcare.com. ✧

This article was excerpted from HPW sister publication Medicare Advantage News*. For more information or to order, visit https://aishealth.com/marketplace.*

State Laws Aim to Save Markets

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Ashley Williams, research fellow at the Center on Health Insurance Reforms at Georgetown University Health Policy Institute, tracks health insurance-related state legislation in all 50 states and the District of Columbia. "We are currently in a moment when there is a lot of uncertainty," Williams says. "States are taking steps to save their markets."

With that as a main focus this year, some states are taking action with Section 1332 waivers, under which states apply for permission to bypass certain ACA requirements in order to experiment with different ways to provide health coverage. Some states are seeking to pass laws to gain the authority to file an application for a 1332 waiver, while others are looking to study the waivers to determine if they would like to apply, she says.

Even if the ACA is repealed or amended, states have looked at what they want to preserve from the ACA, if anything, and how they want to preserve it, Williams says. This has taken shape in several ways. States like New York have passed laws to stabilize their market. Some states are asking, even if the ACA is repealed, "how can we move forward?" Some are looking for stopgap measures.

UnitedHealth Group Taps New CEO

After years of preparation, UnitedHealth Group recently announced a CEO change. David Wichmann, president of the nation's largest health insurer since 2014, will become CEO and a director of the company effective Sept. 1. On that date, Stephen Hemsley, the current CEO, will become executive chairman of the board of directors, a newly created post, and Richard Burke, the current board chairman, will become "lead independent director."

In its Aug. 16 press release, UnitedHealth Group said the changes "are designed to ensure continuity as the company continues to grow and evolve." Hemsley, 65, said this is "the right time for this transition to take place" given that the company "is performing strongly and has a positive outlook" for the future. Hemsley said Wichmann, 54, has worked nearly two decades for UnitedHealth and has "deep expertise" in critical areas, "especially growth-oriented technology, operations and global markets."

Credit Suisse analyst Scott Fidel said UnitedHealth has been "methodically preparing" for the leadership transition for years and there was never any doubt that Wichmann would become the next CEO. "The only real question was when UnitedHealth would decide to make the change," Fidel said in an Aug. 16 note. "From a timing perspective, United is making this announcement from a position of strength; its operations are highly stable, the company is growing robustly, and the overall financial profile is in pristine condition."

On July 18, UnitedHealth reported better-than-anticipated profits for the quarter ended June 30 *(HPW 7/24/17, p. 3)*. Since Hemsley became CEO in November 2006, UnitedHealth's value has grown remarkably, Fidel said. "The fact that Hemsley plans to remain heavily engaged in the company's strategy for years to come as executive chairman will likely be very well received by investors," he said.

Wichmann joined UnitedHealth in 1998 and served as chief financial officer from 2011 to mid-2016.

Contact Fidel at scott.fidel@credit-suisse.com. See UnitedHealth's announcement at http://tinyurl.com/yb6fu9ua.

by Judy Packer-Tursman

Then, there are a lot of downstream issues, Williams adds. One such issue is out-of-network billing. States have been working on how to protect consumers from out-of-network billing surprises by upping the protections in their laws. Others are looking to further define out-of-network billing protections in their state, she says.

NCSL's Database Provides Insight

The NCSL Health Innovations State Law Database tracks enacted laws and includes information on state health transformation initiatives and related changes in state statutes.

The database, searchable by more than a dozen categories, so far this year has tracked a total of 240 laws on health care passed in 39 states and the District of Columbia. Between January 2015 and November 2016, NCSL identified more than 800 health care laws and resolutions in all 50 states, D.C. and Puerto Rico.

According to Cauchi, this year, NCSL's database shows a number of key hot spots around which states enacted laws related to health insurance. They are:

◆ ***Market Mandates and Essential Health Benefits:*** This category drew the most activity, with 22 laws passed in 15 states, including everything from mandating coverage for a 12-month supply of birth control pills to autism testing, teledentistry and more. Alabama and Iowa passed laws requiring health plans to cover autism care, while Colorado, the District of Columbia, Nevada and Virginia passed laws mandating coverage for reproductive health care and contraceptives. Arkansas mandated coverage of telemedicine and New Jersey required substance use disorder benefits. Oregon enacted a law on behavioral health services. "States have an ongoing interest in new mandates, given the complexity of federal health laws," Cauchi says.

◆ ***Network Adequacy:*** In one of the strongest moves to protect its citizens against federal efforts to thwart ACA marketplaces, Hawaii passed a law that "requires a health carrier with a network plan to maintain a network that is sufficient in numbers with appropriate types of providers to ensure that covered persons have access to covered services." Maine, Texas and Virginia passed laws to look at the broader question of network adequacy. These laws indicate that states are not waiting for the federal government to "fix" issues related to health care access, Cauchi says.

◆ ***Out-of-Network Billing Issues:*** This year some states focused on out-of-network billing issues posing difficulties for beneficiaries. Arizona, Louisiana, Maine, Montana and Texas all passed laws addressing this issue, with some including the use of mediation and instituting a cap on how much a beneficiary must pay for "surprise" bills.

◆ ***Free Market Challenges and Alternatives:*** Arkansas and West Virginia passed laws to prohibit a state-run exchange. Oklahoma passed a law to allow buying insurance out of state, joining Georgia, Maine and Rhode Island, which already had such laws on the books. This option to buy across state lines was used in GOP campaign platforms in recent elections, but some have questioned the workability of such an option, Cauchi says. Evidence collected by NCSL shows that not one person has ever been able to purchase an out-of-state policy based on these laws. Several ACA replacement laws have had a version of this measure included. Insurance companies will continue to play a major role as to whether this succeeds or not. So far, no insurers have come forward to say they want to make this work, yet many operate in multiple states, with little to prevent them from enabling such purchases.

"The commercial concept is not far off, but what's missing is an endeavor to make it happen," Cauchi says.

◆ ***Direct Primary Health Care:*** A new trend this year has been the passage of laws that allow patients to directly contract with physicians for their care, bypassing insurance, as allowed under the ACA. This year, Arkansas, Colorado, Indiana, Kentucky, Maine and Virginia all passed such laws. It is not clear if any patients are using the method to purchase health care, Cauchi says. It's still unclear whether this will threaten health plans. Most of the laws have been set up with no regulatory oversight, and thus no agencies to collect data on how many people are using such contracts.

◆ ***Protection or Adoption of ACA Provisions:*** Several states including Maryland, Minnesota and Rhode Island tackled laws in this category. Alaska, Maine, Oklahoma and Washington passed laws dealing with risk pools and reinsurance. California passed a law to allow immigrant coverage, and Maryland enacted a statute to prevent drug manufacturers from price-gouging. None of these laws were alike, Cauchi says. Each state passed provisions designed to protect portions of the ACA they like. There are plenty of other bills in the pipeline in this category, he says.

◆ ***1332 Waivers:*** According to NCSL, 21 states have thus far initiated activity to apply for a Section 1332 waiver. Alaska, California, Kentucky, New Hampshire and Oklahoma all passed laws this year related to 1332 waivers. This category is one to watch for next year, and is likely to result in more laws being passed, Cauchi says.

Contact Cauchi at health-info@ncsl.org, Collins at SRC@CMWF.org and Williams at Ashley.Williams@georgetown.edu. Access the NCSL Health Innovations State Law Database at http://bit.ly/2v37HsZ. ✧

by Diana Manos

Key Financial Data for Leading Health Plans — Second Quarter 2017 (Year-to-Date)

See more health plan financial data — including year-over-year comparisons of leading health plans' net income, premium revenue, medical loss ratios and net margins — at *Health Plan Week*'s subscriber-only Web page at http://AISHealth.com. Click on Key Financial Indicators to access the data. *HPW* subscribers received a link to a complimentary Excel spreadsheet with this data, along with links to prior quarters, in the email that transmitted the PDF version of the newsletter. If you are an *HPW* subscriber and do not receive subscriber emails, please contact custserv@aishealth.com or call (800) 521-4323.

Company	Premium Revenue	Hospital/Medical Costs	Pharmacy Costs	Total Medical Costs	Medical Loss Ratio	Administrative Costs	Admin. Expense Ratio	Net Income (Loss)	Net Margin
Aetna, Inc.	$26,442,000,000	$21,493,000,000	$0	$21,493,000,000	81.28%	$5,582,000,000	21.11%	$822,000,000	3.11%
Anthem, Inc.	$41,764,400,000	$35,460,000,000	$0	$35,460,000,000	84.90%	$5,551,000,000	13.29%	$1,865,200,000	4.47%
Arkansas BCBS	$1,262,955,017	$582,483,736	$270,663,091	$1,082,028,971	85.67%	$103,699,210	8.21%	$19,190,281	1.52%
BCBS of Alabama	$2,861,073,202	$1,313,015,419	$546,310,613	$2,443,233,560	85.40%	$156,226,368	5.46%	$184,034,045	6.43%
BCBS of Arizona	$1,060,992,594	$491,116,557	$152,882,650	$804,910,924	75.86%	$63,454,026	5.98%	$98,155,663	9.25%
BCBS of Florida	$5,028,308,900	$2,836,805,732	$838,237,065	$4,083,961,052	81.12%	$393,137,382	7.82%	$296,686,869	5.90%
BCBS of Kansas City	$912,251,522	$583,208,878	$81,117,406	$686,438,645	75.25%	$80,794,216	8.86%	$40,242,319	4.41%
BCBS of Louisiana	$1,206,483,861	$702,994,584	$219,764,405	$929,931,411	77.08%	$119,954,262	9.94%	$101,068,017	8.38%
BCBS of Massachusetts	$3,703,894,357	$2,473,102,685	$603,063,745	$3,400,560,877	91.81%	$199,053,375	5.37%	$19,927,584	0.54%
BCBS of Michigan	$5,929,092,952	$3,750,866,122	$702,463,294	$4,792,978,875	80.84%	$625,947,213	10.56%	$360,162,070	6.07%
BCBS of Minnesota	$2,972,424,011	$2,064,300,748	$317,307,779	$2,570,656,174	86.48%	$188,077,279	6.33%	$39,644,410	1.33%
BCBS of Nebraska	$834,047,641	$545,302,357	$113,629,141	$674,375,956	80.86%	$56,933,905	6.83%	$39,619,736	4.75%
BCBS of North Carolina	$4,507,909,700	$2,189,213,832	$743,696,094	$3,326,559,633	73.79%	$356,692,011	7.91%	$542,889,193	12.04%
BCBS of Rhode Island	$860,507,705	$505,535,803	$124,138,213	$748,293,059	86.96%	$82,704,287	9.61%	$22,109,534	2.57%
BCBS of South Carolina	$2,002,110,311	$929,612,565	$375,332,423	$1,716,227,115	85.72%	$160,992,751	8.04%	$73,976,015	3.69%
BCBS of Tennessee	$2,302,602,992	$1,253,128,202	$363,558,690	$1,746,969,550	75.87%	$174,256,212	7.57%	$201,335,115	8.74%
Blue Shield of California	$7,102,918	$5,154,572	$973,282	$6,127,854	86.27%	$506,722	7.13%	$115,138	1.62%
Capital Blue Cross	$406,626,372	$275,526,576	$22,298,564	$360,678,419	88.70%	$43,427,898	10.68%	$17,849,272	4.39%
CareFirst BCBS	$4,338,866,869	$2,310,011,822	$899,271,347	$3,602,226,052	83.02%	$465,440,600	10.73%	$31,902,958	0.74%
CareSource	$4,059,089,548	$2,517,406,814	$846,086,767	$3,564,648,722	87.82%	$503,068,492	12.39%	($45,315,303)	-1.12%
Centene Corp.	$21,543,000,000	$18,735,000,000	$0	$18,735,000,000	86.97%	$2,156,000,000	10.01%	$393,000,000	1.82%
Cigna HealthCare	$16,113,000,000	$9,909,000,000	$1,207,000,000	$13,818,000,000	85.76%	$4,801,000,000	29.80%	$1,403,000,000	8.71%
EmblemHealth, Inc.	$3,488,958,749	$2,577,383,298	$453,711,519	$3,170,574,605	90.87%	$342,887,721	9.83%	($13,396,801)	-0.38%
Harvard Pilgrim Health Care	$1,519,861,930	$978,187,246	$229,515,523	$1,341,137,689	88.24%	$160,999,531	10.59%	($4,958,487)	-0.33%
Hawaii Medical Service Assn.	$1,682,324,830	$1,278,613,958	$197,830,910	$1,537,544,890	91.39%	$87,486,429	5.20%	$31,238,058	1.86%
Health Alliance Plan of Michigan	$988,908,769	$703,795,937	$123,104,303	$888,007,824	89.80%	$84,162,253	8.51%	$1,129,916	0.11%

Company	Premium Revenue	Hospital/ Medical Costs	Pharmacy Costs	Total Medical Costs	Medical Loss Ratio	Administrative Costs	Admin. Expense Ratio	Net Income (Loss)	Net Margin
Health Care Service Corp.	$16,657,438,056	$10,648,509,559	$2,186,154,477	$12,960,840,290	77.81%	$1,171,386,969	7.03%	$1,236,477,464	7.42%
Healthfirst Health Plan, Inc.	$1,126,273,832	$776,971,835	$105,709,390	$985,369,112	87.49%	$117,977,192	10.48%	($8,358,306)	-0.74%
HealthNow New York, Inc.	$1,246,843,008	$756,884,351	$207,210,868	$1,119,654,791	89.80%	$95,195,318	7.63%	$21,068,821	1.69%
HealthPartners	$840,528,719	$866,101,669	$140,882,800	$1,065,438,712	126.76%	$106,241,421	12.64%	$18,139,456	2.16%
Highmark, Inc.	$4,654,724,214	$2,352,094,247	$554,724,199	$2,953,697,234	63.46%	$195,109,425	4.19%	$439,700,209	9.45%
Humana, Inc.	$26,601,000,000	$22,215,000,000	$0	$22,215,000,000	83.51%	$3,006,000,000	11.30%	$1,765,000,000	6.64%
Independence Blue Cross	$5,072,832,493	$3,649,951,785	$321,335,530	$4,424,076,843	87.21%	$447,392,091	8.82%	$73,200,510	1.44%
Kaiser Permanente	$7,395,594,272	$2,998,383,765	$943,005,109	$6,894,107,620	93.22%	$428,288,175	5.79%	$162,427,056	2.20%
Lifetime Healthcare Companies/Excellus	$2,873,021,907	$1,621,588,774	$475,239,534	$2,396,251,035	83.41%	$176,944,136	6.16%	$127,251,962	4.43%
Medica Health Plans	$2,106,354,495	$1,596,877,498	$215,902,431	$1,973,209,950	93.68%	$186,770,275	8.87%	$85,585,340	4.06%
Medical Mutual of Ohio	$1,220,188,021	$652,457,247	$140,989,792	$948,600,188	77.74%	$95,922,438	7.86%	$67,622,520	5.54%
Moda Health Plan, Inc.	$286,559,772	$174,650,664	$38,259,859	$264,901,061	92.44%	$7,974,091	2.78%	$23,238,787	8.11%
Molina Healthcare	$9,388,000,000	$8,602,000,000	$0	$8,602,000,000	91.63%	$844,000,000	8.99%	($153,000,000)	-1.63%
MVP Health Care	$1,248,168,141	$840,932,747	$205,307,867	$1,164,266,297	93.28%	$75,280,174	6.03%	$431,501	0.03%
Premera Blue Cross	$1,742,650,632	$1,043,282,388	$191,545,392	$1,464,546,773	84.04%	$118,292,117	6.79%	$76,558,820	4.39%
Priority Health	$1,893,908,299	$1,240,400,503	$249,022,114	$1,631,040,732	86.12%	$124,614,304	6.58%	$75,002,899	3.96%
Regence Group, The	$2,797,416,475	$1,370,997,497	$381,117,172	$2,300,452,996	82.23%	$199,477,785	7.13%	$131,310,746	4.69%
SelectHealth	$1,322,128,971	$812,939,511	$177,932,348	$1,203,211,990	91.01%	$76,792,444	5.81%	$15,770,873	1.19%
Triple-S Salud Inc.	$778,082,445	$380,036,911	$244,944,410	$680,964,885	87.52%	$64,671,940	8.31%	$25,970,328	3.34%
Tufts Associated Health Plans	$2,296,268,189	$1,577,408,787	$349,426,544	$2,041,590,857	88.91%	$167,457,272	7.29%	$39,612,405	1.73%
UnitedHealth Group	$78,523,000,000	$64,628,000,000	$0	$64,628,000,000	82.30%	$14,350,000,000	18.27%	$4,541,000,000	5.78%
UPMC Health Plan	$2,150,585,887	$1,165,181,873	$385,618,938	$1,961,616,910	91.21%	$164,788,758	7.66%	$29,253,850	1.36%
WellCare Health Plans	$8,240,600,000	$7,197,600,000	$0	$7,197,600,000	87.34%	$667,900,000	8.10%	$141,400,000	1.72%
Wellmark, Inc.	$1,909,472,935	$1,051,851,642	$192,516,446	$1,523,937,659	79.81%	$198,022,806	10.37%	$94,826,692	4.97%

NA=not available. Medical Loss Ratio=Medical Costs/Premium Revenue. Net Margin=Net Income/Premium Revenue. Administrative Cost Ratio=Admin Costs/Premium Revenue

Notes: Group Health Cooperative operations are now included in Kaiser Permanente. Moda Health Plan, Inc., is new to this table for 2017.

SOURCE/METHODOLOGY: Prepared by AIS researchers based on selected data points from annual and quarterly financial statements filed with the U.S. Securities and Exchange Commission and relevant state insurance departments. Health plans have been selected based on medical risk enrollment as of beginning of 2017, per *AIS's Directory of Health Plans: 2017*. The data set represents companies identified as Health Insurance, HMO and Hospital, Medical and Dental Service or Indemnity (HDMI) companies. Data are not available for companies identified as life and health, disability, annuity or other insurance companies. Data may represent dental, vision and other lines of business in addition to medical benefits. Some companies are consolidated, representing two or more subsidiaries with premium revenue. Some cost breakdowns may be unavailable. Costs may be defined differently by different sources; administrative costs may or may not include cost of sales. Medical costs include hospital/medical and pharmacy costs, prior to reinsurance recoveries. The publisher does not warrant that the information contained herein is complete or accurate.

HEALTH PLAN BRIEFS

◆ **The Congressional Budget Office (CBO) said Aug. 15 that gross premiums for silver plans in the Affordable Care Act (ACA) individual marketplace would increase by 20% in 2018 if cost-sharing reduction (CSR) payments were terminated.** By 2020, these premiums would be 25% higher than if CSR reimbursement continues. If CSR payments are halted after rates are finalized or plans begin charging premiums that don't incorporate such a change, "insurers would suffer significant financial losses," CBO said. "To reduce those losses, some insurers would exit the marketplaces in the middle of the year. Some of those marketplaces would have no insurers remaining — reducing federal costs but increasing the number of people who were uninsured." Read CBO's report at http://tinyurl.com/ybd4qyk4.

◆ **CMS on Aug. 15 issued a proposed rule that would reduce from 67 to 34 the number of mandatory geographic areas participating in its Innovation Center's Comprehensive Care for Joint Replacement model.** CMS seeks to make participation in the model voluntary for all low-volume and rural hospitals in all geographic areas. Also, CMS proposed cancelling the Episode Payment Models and the Cardiac Rehabilitation Incentive payment model, both scheduled to begin Jan. 1, 2018. The Trump administration says its proposals would offer greater flexibility and choice for hospitals in orthopedic care for Medicare beneficiaries. Public comments are due by Oct. 16. View the 86-page proposed rule at http://tinyurl.com/ya2796ev.

◆ **After a nine-month hiatus to boost its financial reserves, the Montana Health CO-OP, a nonprofit Consumer Operated and Oriented Plan (CO-OP) created under the Affordable Care Act (ACA), resumed accepting new enrollees on Aug. 12,** AP reports. The plan withdrew from the state's health insurance exchange in 2016 amid worries about its financial health. It will join Blue Cross Blue Shield of Montana and PacificSource on the exchange for 2018. See http://tinyurl.com/y6w7mp2h.

◆ **For its new program expanding Medicaid managed care statewide, Illinois awarded new contracts on Aug. 11 to six managed care organizations,** including subsidiaries of incumbents Centene Corp., Molina Healthcare, Inc. and WellCare Health Plans, Inc. The contracts are scheduled to go live Jan. 1, 2018. Credit-Suisse analysts noted that incumbent Aetna Inc. was the only publicly traded MCO left off the list of awardees, among those companies bidding on the state's request for proposal (RFP) issued in February. According to analysts, the new program, which integrates physical and behavioral health, will cover roughly 2.7 million people in all of Illinois' 102 counties, up from about 2 million people under current contracts. Go to http://tinyurl.com/yd8qvzmp.

◆ **Missouri-based Centene Corp., known as SilverSummit Healthplan in Nevada, will offer health insurance coverage to Nevada residents statewide on the Silver State Health Insurance Exchange,** Gov. Brian Sandoval (R) said Aug. 15. After the exits of Prominence Health Plan and Anthem Inc., the state's Division of Insurance anticipated that 14 of Nevada's 17 counties would lack an on-exchange option, which would have left 8,000 consumers without access to qualified health plans and federal subsidies starting Jan. 1. While 2018 exchange contracts are not yet finalized, UnitedHealth Group unit Health Plan of Nevada expects to participate on the state's exchange in three counties, leaving SilverSummit as the only carrier set to offer statewide coverage comprising numerous rural regions. Go to http://tinyurl.com/y9bn7swy.

◆ **Apple and Aetna Inc. held secret meetings in southern California during the week of Aug. 7 to discuss bringing Apple Watch, a wearable health and fitness tracking device, to the insurer's 23 million members,** CNBC reports. Aetna, which already offers Apple Watch to its 50,000 employees as part of its corporate wellness program, is now negotiating with Apple on a plan to offer a free or discounted Apple Watch as a perk to its members, CNBC says. Both companies declined to comment on the matter. See http://tinyurl.com/y92xl6ct.

◆ **Anthem Blue Cross Blue Shield said Aug. 11 it is leaving the individual-market Affordable Care Act (ACA) exchange in Virginia for 2018.** The individual market "remains volatile" and is "shrinking and deteriorating," Anthem said. It becomes the third plan to exit Virginia's exchange, along with UnitedHealthcare and Aetna Inc. Anthem will continue to offer off-exchange individual plans next year in Virginia's Washington and Scott counties and the city of Bristol. See http://tinyurl.com/y8b8f67o.

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