



John Gorman On CMS Reg Blitz

"The playing field of government programs continues to expand rapidly, with improving revenue outlook across the board...CMS is on pace for its most aggressive enforcement year ever." p. 4

## hotspots...

### Big Surprise: Study Shows Limits Of Exchange Potential

ACA "exchanges" may end up de facto Medicaid enrollment platforms without much upside for commercial growth, according to the first detailed analysis of coverage by the top-rated **National Bureau of Economic Research**. For instance, offering access to exchanges by the uninsured only increased insurance coverage by one percent in 2014. Consumer fear of tax penalties had *no* impact, and the *individual mandate did nothing* in the first year.

What achieves huge reductions in the uninsured is good old Medicaid. Subsidies help, but are almost a side show and such a small piece of premiums they barely influence market coverage.

Bottom line: the exchange premium subsidies produced only 37% of the ACA's 2014 coverage gains, while Medicaid claimed 63%, of which 2/3 occurred among already-eligible individuals (versus "expansion" recipients). "The fact that our calculated premium subsidy elasticities were fairly low hints at the uphill climb the law may face in continuing to build on the initial coverage gains of its first year." Medicaid's share will definitely rise faster.

States are going crazy over this since they only get the 90% federal subsidy for *newly-enrolled* Medicaid expansion recipients. But the exchanges are adding millions of Medicaid recipients who were *already eligible*. So states don't get the 90% match for a whopping 2/3 of the Medicaid recipients coming on board through an exchange -- they get their existing lower rate, hiking state spending. States will thus be forced to cut their Medicaid spending per capita pronto, just at a time when **CMS** is asking them to start adopting value-based purchasing in the new Medicaid reforms.

This should accelerate their commitment to Medicaid cost-saving reforms, but most of the big stuff will take years. In the meantime they are stuck with hundreds of millions in over-runs.

Health plans were hoping that ACA exchanges would become the cornerstone of individual lines of business, but now have mixed emotions. New enrollment (and revenue) gains from exchanges could be maxing out after the first couple years, and the recent rash of dropouts and premium hikes could easily cause a net decline. The study reassures plans that Medicaid is not replacing or "crowding out" private market coverage in exchanges.

But it is growing the fastest from a hidden exchange population already eligible before exchanges, yet just plugged in. By 2020 it looks like ACA exchanges could be 90% "Medicaid exchanges."

For the huge Medicaid health plans like United, Molina and Centene, the added Medicaid recipients will be a plus since most will be in families and couples, not costly single adults. And with the new Medicaid reforms coming, a larger population base will help Medicaid plans leverage the coming shift to Medicaid long-term care and dual-eligible plans. They also can hope that the coming Medicaid value-based reforms -- across Medicaid, Medicare Advantage and the exchanges -- will some day allow private insurers to avoid endemic ACA losses this year and rise again.

## market notes...

**CareFirst Blue Cross BS of Maryland** is dropping its Bronze plan, which has a higher deductible and lower premium -- but also a smaller premium increase and less potential profit. Members will likely move to a more costly Silver plan with higher profit margins and bigger premium increases. This bodes poorly for the theory that everybody will move into the lowest-priced Bronze plans over time despite higher deductibles to save money. Blues plans in most states have never offered HSAs with high deductibles, and Silver plans remain the most-popular choice with the biggest margins. **CMS** data shows Bronze is the only metal level where insurers in the individual and group markets had to pay into the program.

**Humana** and **Aetna** both dropped big hints that they will be pulling back from their ACA markets next year, probably after the election given the timing of required filings. Humana in its 1Q 2016 fiscal year earnings noted its ACA coverage enrollees dropped 21% to 875,700 customers, compared with 1.1 million during the same quarter last year. It told investors it is in the process of "finalizing plans for its ACA-compliant individual commercial medical market offering in 2017," and changes may include "certain statewide market and product exists both on and off the exchange, service area reductions and pricing commensurate with anticipated levels of risk by state." Overall, the company experienced a 46% decrease in profit. **Anthem** says it will stay in (across 14 states) and targets margins of 3% to 5% -- by 2018.

**Big changes in PPO network ownership** A little-noticed *WSJ* story says **MultiPlan**, the massive PPO contractor for both **Cigna** and **Humana**, is being sold by former **AIG** chief **Hank Greenberg** (Starr Investments) who owns Multi-Plan to its fifth or sixth private equity firm after two years. Analysts saw two interesting motives: the pending acquisition of Cigna and Humana by non-clients like **Aetna**, which has its own PPOs, and the accelerating move to ditch fee-for-service on which PPOs have depended for decades. PPOs in commercial markets are being replaced by global payments, value-based contracts and network-free products. Humana for example will no longer will sell any PPOs on *HealthCare.gov*. But Medicare is the opposite: PPOs are the fastest-growing product in Medicare with several avenues of growth.

**Medicare.gov Moves To Cloud** The popular and seamless *medicare.gov* portal has moved to the cloud with **Amazon** in what experts say is a potential historic shift in government website contracting. The original objective was for *healthcare.gov* (and *cms.gov*) to move to the Amazon cloud service, and a contract was let for storage. But all of the problems and changes in the ACA implementation delayed HHS using the cloud. Instead, the smooth-working *medicare.gov* website, the original government health "exchange" which pre-dates the ACA, started to work with its vendor to figure out the problems with HIPAA and security issues.

It made the jump in March. Long-time contractor **Connecture** (owner of *medicare.gov* contract-holder **DRX**) says this paves the way for other government agencies to use the new connectivity, and *allows all health plans to move to Amazon* as well. "This will be especially attractive because enrollment using a legacy server is

wasteful, compared with a cloud server which can add or remove capacity due to the quarterly variations in enrollment.”

### Only Writes Off A Billion If GOP Retains Majorities In Fall **Aetna Bets ACA Future On Election Results**

Aetna CEO **Mark Bertolini** said in a *Forbes* article that the company’s future in the ACA exchanges depends on a different, post-election Congress making major changes in ObamaCare instead of repealing it, a stance which implies an Aetna pullout is possible after the election unless something happens like the White House and the House are taken over by Democrats.

The dice don’t favor this bet. And current leading GOP replacement proposals all eliminate the ACA exchanges and replace them with tax credits, while the small group ACA exchanges which already have separate risk pools have been total failures in attracting significant enrollment. Most states will probably keep their exchanges, but fixing how they work is out of their hands.

But Bertolini was realistic. “We see this as a good investment, hoping that we have an administration and a Congress that will allow us to change the product like we change Medicare every year and we change Medicaid every year,” the CEO said in the *Forbes* piece. “But we haven’t been able to touch this product because of the politics. But if we get to that point, we are in a very good place to make this a sustainable program.” No mention was made of the alternative if this doesn’t happen, but the implication was clear: selective reductions.



[The only scenario we can imagine that would allow the list to be adopted before the election would be the **Paul Ryan** blueprint which is supposed to be out in June. But in recent days that entire effort is in doubt given the current brouhaha with **Trump**, who has never detailed anything, but says it does not back Ryan’s ‘agenda.’]

Pulling out next year *would not damage the company* very much though on paper. Some analysts believe that Aetna will lose several hundred million next year, and Bertolini hinted that the cumulative losses so far are fast-approaching the cost of staying in. “If we were to go out and buy those members, it would cost us somewhere around \$1.2 billion to acquire them,” Bertolini said. “If we were to build out 15 markets, it would cost us somewhere between \$600 million to \$750 million to enter those markets and build out the capabilities necessary to grow that membership.”

The Aetna CEO cited a critical list of major changes in the statute that will have to be made by the next Congress, including a *total re-design of the risk pool structures* (presumably breaking one pool into large group, small group and individual), with *different premiums for each pool*. Also needed is a *major re-engineering of product flexibility* tied to the new risk pools.

“We need different pools, not one pool,” Bertolini said. “Cross-subsidizing at the premium level across a large swath of the population doesn’t work. It needs to be multiple pools with specific products for each pool.” He compared this to the way the Medicare and Medicaid programs evolved in the first few years.

Another analogy is the way the early *national health insurance* plans fared in the 1920s. Aetna led the charge in favor of state-run health exchanges – but it took 90 years before Congress agreed.

### **Health Plans And Affinity Groups Tap In-Store Benefits** **Walmart Joins InComm Consumer Payments**

InComm, the top retail consumer health payments firm, unveiled a major expansion by adding **Walmart** to its global network of more than 450,000 points of retail distribution worldwide using InComm Healthcare & Affinity’s (IHA) Enhanced Payment Platform. Members of more than *90 health plans with cards issued by IHA* can now participate in health plan-sponsored wellness programs and receive benefits at Walmart locations nationwide.

“The addition of Walmart to our network of retailers is a major milestone for our platform that significantly expands the value we can provide to the health plans and affinity groups we serve,” said **David Vielehr**, SVP/GM at IHA. “Our vision has always been for our Enhanced Payment Platform to be at the center of the complete retail wellness offering that includes pharmacy, grocery and lifestyle choices” using a single point of integration for third-party restricted-spend programs.

For Walmart, the platform can support *multiple sponsors, payment types and payers for each program*, significantly expanding the scope of the member benefit. IHA and Walmart will be hosting a complimentary webinar on May 10, 2016, to explain how this partnership can optimize a brand’s utility and encourage plan members to make healthy choices.



### **Medicaid Health Plans Upgrading To Mainstream Levels** **Medicaid Shift Heralds Huge Program Upgrade**

States have invested hundreds of millions building their ACA exchange portals, and millions of new Medicaid recipients are now coming through a state exchange. If you put the two facts together, it seems almost impossible that states will want any future Congress to terminate their work just as it’s getting traction.

That makes the major Medicaid upgrade proposed a year ago and *finalized last week* a critical reform to watch, arguably just as important as the MACRA regs that complement them. People who follow both say Medicaid can now follow MA plan regulations, for instance by using a star-rating systems and better risk adjusters.

A solid overview of the Medicaid shift was compiled by our friends at **Gorman Group** and is summarized here:

**Medical Loss Ratio (MLR)** The final rule directs states to comply with a federal MLR standard of a minimum 85%, with a one-year reporting year. This does not prevent states from setting loss ratios higher than 85%, however. Several states already impose MLR standard on plans, and many plans are already in compliance or close to an 85% MLR, so the impact of this new regulation is uncertain. Time will tell if the imposed 85% MLR will be effective as a way to standardize the varying state rules. CMS estimates the federal government would collect from \$7 to \$9 billion over a span of two years from plans failing to meet the ratio.

**Quality Rating System (QRS)** CMS plans to develop a Medicaid and CHIP QRS, similar to the one currently being implemented in the Exchanges. The new system will align with Exchange indicators but will retain flexibility to use different measures in order to reflect the differences in populations served by Medicaid/CHIP. Overall, the major quality provisions of the rule all work to increase plan transparency of quality information, making it more

## 🚩 Top-Ranked Medicaid Health Plans (NCQA 2014-2015):

1. **Network Health** - HMO (MA)
2. **Fallon Health Plan** - HMO (MA)
3. **Neighborhood Health Plan** - HMO (MA)
4. **Boston Medical Center HealthNet Plan** - HMO (MA)
5. **Neighborhood Health Plan of Rhode Island** - HMO (RI)
6. **Kaiser Foundation Health Plan - Hawaii** - HMO (HI)
7. **UnitedHealthcare Community Plan** - HMO (RI)
8. **AMERIGROUP New York** - HMO (NY)
9. **Meridian Health Plan of Michigan** - HMO (MI)
10. **Meridian Health Plan of Illinois** - HMO (IL)
11. **Priority Health** - HMO (MI)
12. **Upper Peninsula Health Plan** - HMO (MI)
13. **Security Health Plan of Wisconsin** - HMO (WI)
14. **WellCare of New York** - HMO (NY)
15. **Capital District Physicians' Health Plan** - HMO (NY)

available to the consumers and to facilitate identification of high risk members with special health care needs. States will also have the option of waiving out of the federal QRS and establishing their own, if it is substantially similar.

**Quality Incentives** CMS also included several avenues in which states can now develop quality incentive systems in order to move forward with delivery reform and value-based care, similar to the MA and Exchange spaces. States can now enter contractual agreements with plans in which plans agree to work on delivery system reform and performance improvement activities. This will be especially helpful in managing members in need of long term services and support and/or have special health care needs. States can also include value-based purchasing agreements that would tie provider reimbursement to performance on quality measures. Finally, states can develop other incentive and penalty arrangements to reward plans meeting quality or performance.

**Marketing** CMS is updating the marketing standards in order to provide more beneficiary protections due to both the creation of Qualified Health Plans (QHPs) and the changes in managed care delivery systems in the past decade. For example, the new regulation updates rules on the use of mail, email, and websites. The final rule also requires plans to regularly update provider directories and drug formularies and make these readily available. The final rules also codify accessibility and anti-discrimination rules. The new rules greatly align with MA and the Exchange.

**Appeals and Grievances** This is yet another area in which CMS streamlines the process with MA and the Exchange. The new regulation sets clear timelines, definitions, and guidelines for the appeals and grievances process and sets an expedited appeals process. Plans will need to ensure completion of the new required turnaround times for requests for external review; availability of case file medical records, and other documents used to conduct coverage determinations to the member; and documentation of notices and recordkeeping. Enrollees will now also be required to use the new internal process before utilizing state fair hearings.

**Network Adequacy** Though CMS leaves network adequacy details up to the states, it does direct states to establish time and dis-

tance standards for primary and specialty care, behavioral health, OB/GYN, pediatric dental, hospital, pharmacy providers, and Managed Long Term Services and Supports (MLTSS). States will be required to certify the adequacy of the network at least annually or if there is a substantial change in the program design.

**Actuarial Soundness and Rate Setting** CMS established and updated its rate setting procedures in order to bring clarity and ease to setting and reviewing Medicaid managed care payment rates. Currently, rates must simply be “actuarially sound.” The new regulation defines actuarially sound rates as “rates that are projected to provide for all reasonable, appropriate and attainable costs under the terms of the contract and for the time period and population covered under the contract.” CMS also set standards that capitation rates must meet and that CMS will apply in the review and approval of actuarially sound capitation rates.

**Fraud Prevention** CMS also updates procedures to prevent, monitor, and identify fraud, including internal monitoring, audits, and mandatory reporting to CMS. The new rules include procedures for suspending providers when fraud has been alleged. The rule leaves some rulemaking to the states. However, states will need to submit a plan to CMS on how they intend to recover discovered fraud, waste, and abuse.

## Gorman Makes Long-Term Market Projections

### 29 Million MA Enrollees, Dual Eligible SNPs Taking Off

Each year our favorite Medicare prognosticator John Gorman makes public his outlook and market projections. The *Gorman Health Group 2016 Forum* concluded last week with over 200 of its closest clients and partners. Here is his blog update for the market with some quotes from a live interview we conducted a few days later in his office in Washington. A full transcript will be available to subscribers.



The playing field of government programs “continues to expand rapidly, with improving revenue outlook across the board,” Gorman says in his blog. During our interview he sees several years of positive revenue and incentive payments, but only for those companies able to adapt to accelerating market shifts:

■ “We’re sticking by our projections of over 29 million Medicare Advantage (MA) enrollees by 2023, driven by more positive rate trends and a plan-friendly baby boomer tsunami underway.” Confidence levels are reaching new highs, and a series of charts Gorman maintains support the estimate.

■ “Six to eight more states expand Medicaid – once President Obama leaves office.” Probably all except three states will take up the Medicaid expansion when the smoke clears, and Gorman sees almost all states moving to the federal exchange model soon.

■ “Significant enrollment gains for dual eligibles as home and community-based services (HCBS) waivers and managed long-term services and supports (MLTSS) initiatives become the new normal. We expect dual eligible special needs plan (D-SNP) enrollment to double and exceed 4 million by 2019.”

■ “Rising ObamaCare enrollment, albeit slowing and below projections, as more difficult-to-reach populations remain outside coverage.” Commercial markets as embodied in the exchanges have fundamental flaws versus Medicare-Medicaid, and the uninsured reduction may have maxed out already.

■ During the Forum, United announced its departures from most ObamaCare Marketplaces. “We characterized the news as a nothingburger in terms of enrollment or market impact but huge symbolically and politically. We expect another two to three messy years sorting out the pricing and finances of the Marketplace business, with membership reconciliation and cleanup of membership discrepancies front of mind for issuers.”

■ Risk Adjustment Data Validation (RADV) audits “will begin to be conducted in MA 2016-2018 -- the first time we see plans prosecuted under the False Claims Act and hundreds of millions clawed back by the Centers for Medicare & Medicaid Services (CMS) for unsubstantiated codes submitted for higher payments.” This creates massive demand for next generation compliance systems, increasingly using digital platforms.

■ “Clinical and pharmacy data integration and strong provider partnerships around person-centered care were clear priorities [at the event] in medical management, Star Ratings improvement, and Pharmacy Benefit Manager (PBM) oversight.”

■ The Star Ratings system of performance-based payment “drives the payer and provider markets. This year will be the first year where plans below 3 stars are terminated. It’s also when another 180+ MA plans will be scored for the first time, diluting ratings for existing plans, especially those at 4+ stars and denying many their bonuses and rebates in what promises to be an ugly ‘October Surprise.’” Gorman adds that star ratings are far beyond the early years and will drive payments for years.

■ The turbulent Presidential elections “will likely be won by Hillary Clinton, promising continued gridlock with a likely weakened and more polarized Congress. This means CMS will increasingly fight out policy changes ‘below the waterline’ in subregulatory guidance and enforcement, where politicians are less likely to intervene. That means more surprises for plans not paying attention.” Gorman has what may be the most-advanced automated policy/regulatory alert systems for MA plans.

■ “Appeals and grievances and pharmacy benefit management vendor performance remain the #1, 2, and 3 regulatory infractions in MA and integration of long-term care and supports and services the leading challenge facing Medicaid health plans.”

■ “CMS is on pace for its most aggressive enforcement year ever, with over a dozen actions taken against plans this year already.” Gorman sees this expanding regardless of election results as current career agency leaders establish a legacy, particularly since performance savings are now established.

■ “As we’ve said since the passage of the Affordable Care Act, we are now in the Golden Age of government-sponsored health programs, and the opportunities and challenges that come with this shift have never been greater.” Gorman tells us in the interview that companies able to master the changes will be the titans of future markets, but predicted lots of consolidation.

## Kaiser And Mayo Clinic HIT Gurus To Advise

### GAO Taps Health Plan HIT Experts

The **Government Accountability Office (GAO)** has just named three new members of the *Health IT Policy Committee* to represent payers, patients and consumers, and employers. GAO has recently been instrumental in congressional and agency funding decisions for HITECH, and issues like public and private interoperability, international standardization of terminology, and digital platforms.

“It’s important to have the input of key stakeholders in the development of health information technology policy,” Comptroller General and GAO head Gene L. Dodaro said in a public statement. “A number of strong candidates expressed an interest in serving on the Committee, and the individuals being named today will bring highly valuable perspectives to the work of the Committee.”

KP’s **Jamie Ferguson**



Representing *payers*: Fellow of the Institute for Health Policy and Vice President of HIT Strategy and Policy at Kaiser Permanente **Jamie Ferguson**; *patients and consumers*, Senior Editor for MayoClinic.org of Mayo Clinic **Carolyn Peterson**; and *employers*, President and Chief Executive Officer of the Florida Health Care Coalition **Karen van Caulil, PhD**.

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